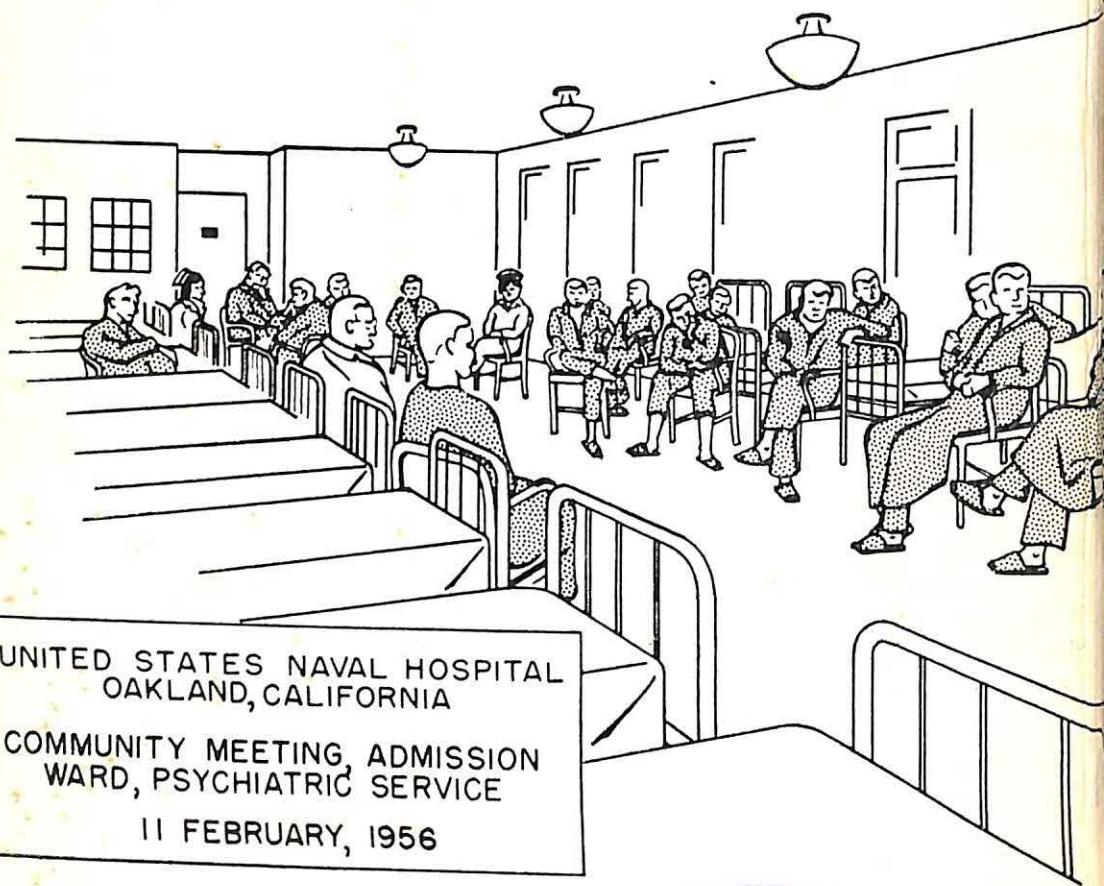
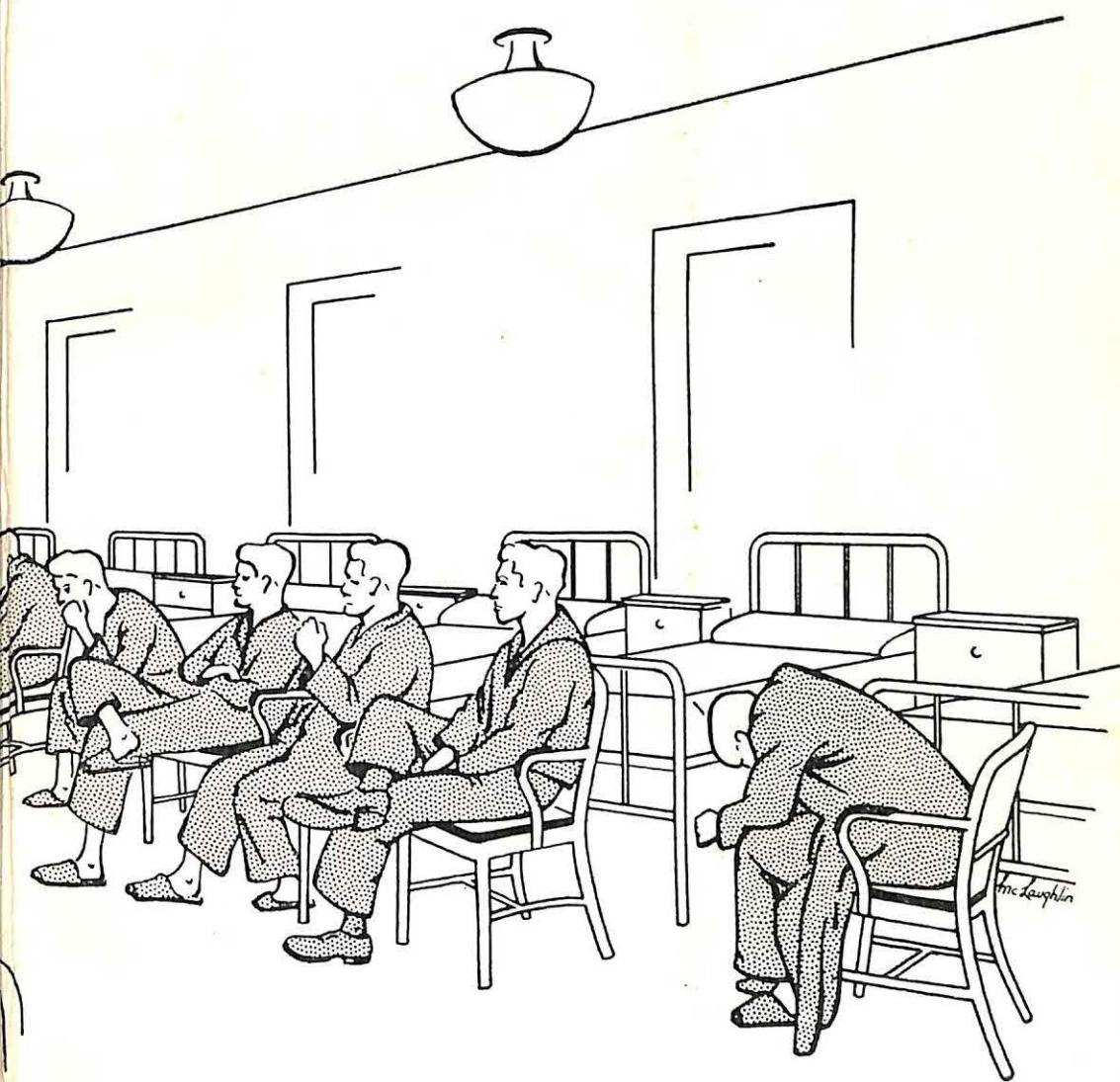


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SOCIAL PSYCHIATRY IN ACTION

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Practical Social Psychiatry, A Therapeutic Community

*(A report to Naval Medical Research
Institute, to be published)*

to SOCIAL PSYCHIATRY IN ACTION

A THERAPEUTIC COMMUNITY

by

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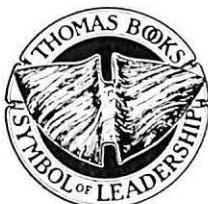
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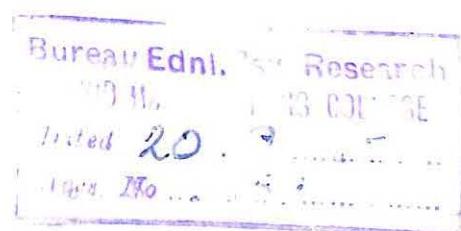
The names of all patients used in this book are fictitious.

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For my wife
and
our children

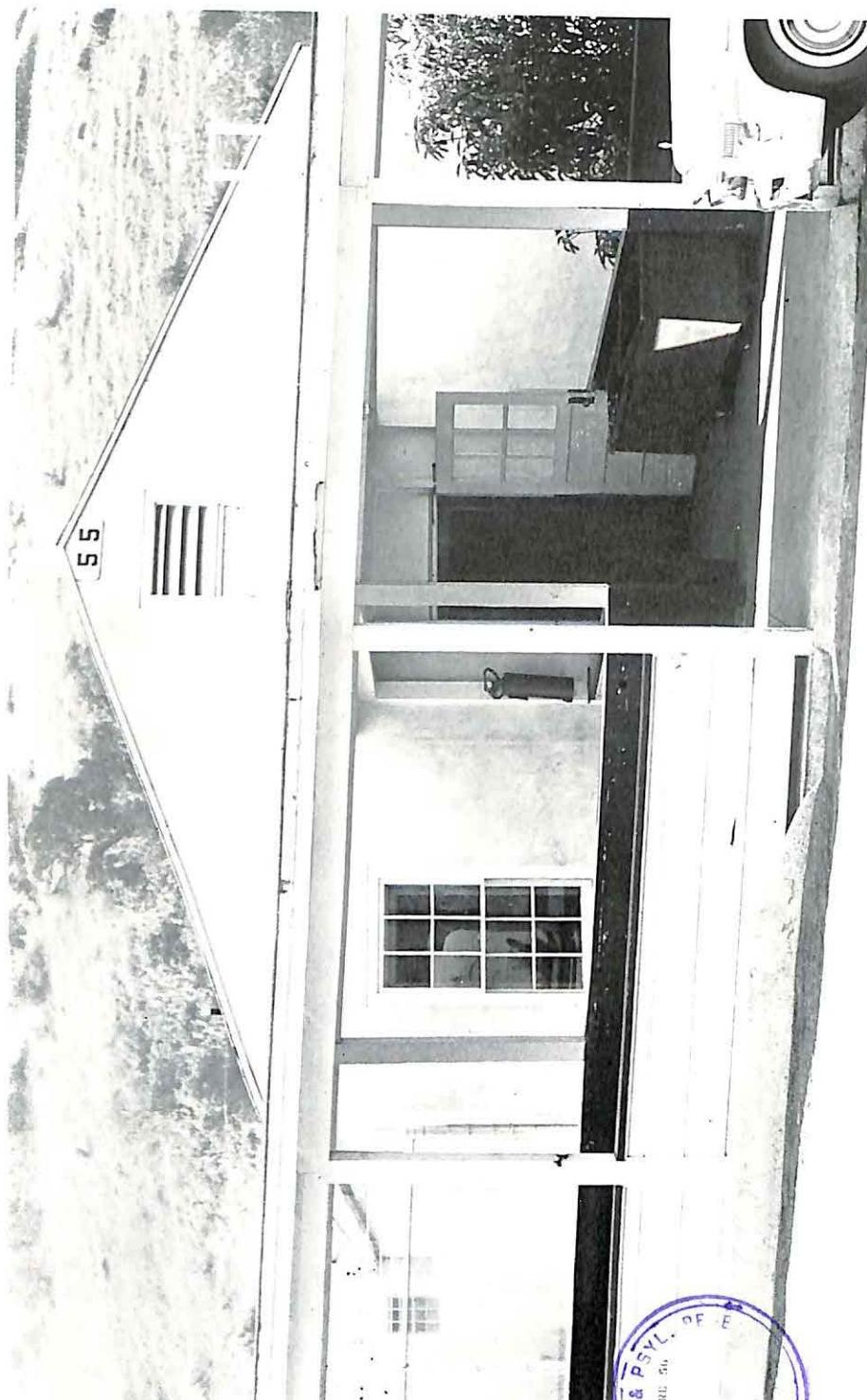
Harry

John

Thomas

James

Mary



The admission ward, psychiatric treatment center, U. S. Naval Hospital, Oakland, California

FOREWORD

The feverish search for specific causes of the so-called functional mental ills continues apace and still these causes remain elusive. As the search continues, the mental hospitals still house half of the nation's hospital beds and, despite the purported miracles of tranquilizing drugs, the influx of patients to them shows little evidence of abating. Meanwhile, psychiatry, the medical discipline entrusted with the care of the mentally and emotionally ill, has made remarkable advances within the past decade and has emancipated itself from confinement behind grim and forbidding hospital walls but, sadly, the mental hospital itself has shared in neither the progress nor the emancipation. For the most part it still stands isolated, remote and alone, testimony to the mores of ages past and by fiat of legislators dedicated to the idea that mental patients must be treated and cared for as cheaply as possible. It stands to reason, therefore, that anyone who brings a fresh new and healthy viewpoint toward the partial solution of these problems, as Doctor Wilmer does in this volume, makes a noteworthy contribution, not only to the care of the mentally ill, but to the welfare of mankind.

By now there is a plethora of evidence that psychological experiences and patterns of reaction are of major etiological significance in any psychiatric disorder, but the mental hospitals for the most part are unable to utilize this knowledge, for they are invariably understaffed, overcrowded, and operating upon limited and skimpy budgets.

Condemned by custom to makeshift expedients, these institutions are unable to do much about the fact that mental illness is often the product of an abnormal environment, or even about the more obvious fact that one does not correct one abnormal environment by introducing another—the still more abnormal environment of the mental hospital ward. It is quite apparent now that many of the symptoms and much of the abnormal behavior of the

disturbed wards are due to abnormal conditions in the wards themselves.

One might hope that the psychiatric wards of general hospitals would be of help, for they are of recent vintage, but they too have their troubles and they are not always the important adjuncts to psychiatric treatment that they should be. The Third Report of the Expert Committee on Mental Health of the World Health Organization (1953) discusses this point. Too often, the report states, the patients in these wards are expected to conform to the pattern of the rest of the hospital, with the patients confined to bed and the nurses engaged in activities that look like general nursing. It is also a fact that these hospitals often refuse admission to patients who are grossly disturbed or who appear to be poor risks. One more difficulty arises in that these hospitals take the most promising material, the acutely ill patients, give them symptomatic treatment immediately and, with the abatement of symptoms, discharge them, with no assurance that the recovery will stand. Eventually then these patients will gravitate to the mental hospitals, with all that this entails.

Though it is much too soon to properly evaluate the ideas and the work which Doctor Wilmer sets forth in this volume, it does seem as though he points the way to the answer to most of the complaints and deficiencies outlined above. He accepts everyone who is sick no matter how noisy or disturbed. He unlooses their fetters and places them in his group; he treats them with dignity, expects them to respond, and invariably they do so. He handles a sizable ward full of patients and, disparate though they and their illnesses might be, he welds them into a community in an environment as nearly normal as one can make a closed ward in a military setting.

In carrying out his work, Doctor Wilmer utilizes the latest in psychiatric and psychoanalytic therapy and understanding. He has the courage, even under provocation and severe stress, to carry out his intention that no one will be "horsed" into the so-called quiet room. While disdaining physical restraint, he is just as adamant against the indiscriminate use of chemical restraint. Withal he is completely reasonable, he does not strain to prove a point and, if he rides a hobby at all, it is that extremely acceptable one of

proving the innate dignity of the human being.

The fact that Doctor Wilmer could carry out these advanced ideas in the military service and deal with overactive young men in the manner which he did, speaks wonderfully well for him and for the understanding of his superiors who aided and abetted him in his humane task. There is much food for thought in this volume. Its implications extend far beyond those of psychiatric treatment alone. As the author points out, people invariably play the role which is expected of them. The role of the patient in the mental hospital usually has been to be sick. Everyone who has ever worked in mental hospitals knows this and has heard the statement: "Well, now that I am in here, I might as well act crazy." In Doctor Wilmer's therapeutic community the role assigned the patient is that of a responsible member of society. It is expected that he will conform as nearly as possible to the norms of society and the major objective is to foster self-control.

The question will naturally arise: How much of the success of this venture is due to the system and how much is due to Doctor Wilmer? Undoubtedly much of it is due to the doctor; however, he asked for no quarter. He was physician, therapist, group leader, Naval officer, and administrator all in one. His secret is betrayed in Chapter V when he starts the forty mile drive to the hospital in order to help a patient get to sleep. The care of the patient is a matter of caring for the patient, he recalls to us, and this may often mean caring enough about him to lose sleep over him rather than take an easy way out by indiscriminately handing out pills. The dedication of a doctor to his patients and his ideals stands out throughout the work.

If it were possible, Doctor Wilmer should be endowed and sent throughout the nation as a teacher and as a catalyst. He has the ability to enthuse his hearers and his dedication furnishes an excellent example for young physicians. A community should be started in every admission ward of every mental hospital in the country. However, neither this commentator nor Doctor Wilmer believes that he has found the answer to our hospital problems or to the treatment of mental disease; he hasn't, but he has pointed some new directions to us. All are aware that he kept his patients only ten days and there is a great difference

between these patients and the chronically ill. He has demonstrated, however, that people, no matter how ill they are, can be influenced by their environment, and he has pointed a new direction for future research in group methods and in social psychiatry.

Doctor Wilmer acknowledges that the seeds of his ideas were borrowed from our British colleagues, Jones, Main, and Rees, but I am sure that they would join us in pointing out that these seeds have germinated in Doctor Wilmer's fertile mind and that he has accomplished a mission for the mentally ill which could have widespread potentialities for great good. That he has done this in a military setting with unselected cases is all the more remarkable.

Probably the best comment upon this work which I have read was made by the distinguished president of the American Psychoanalytic Association, Doctor William G. Barrett, who said: "I believe that the therapeutic community mode of treatment as presently practiced by Doctor Wilmer is one of the most hopeful developments in psychiatry from both the administrative and psychotherapeutic points of view." With this belief I heartily agree.

FRANCIS J. BRACELAND, M.D.

President, American Psychiatric Association,

1956-57

Hartford, Connecticut

PREFACE

As a result of experiences in the military service in World War II psychiatry in the United States received its greatest impetus in this century. It is regrettable that those advances came upon the heels of a holocaust, but it is gratifying to note that the present progressive therapeutic venture of Doctor Wilmer, as outlined in this volume, occurred in peacetime and under the interested auspices of the Medical Corps of the U. S. Navy. There have been so few really noteworthy advances in the treatment of hospitalized psychiatric patients that the work herein reported is particularly welcome at this time.

The Navy had no difficulty in accepting and even becoming enthusiastic about Doctor Wilmer's research efforts—his research plan was eminently reasonable; his directions were toward a refinement of the humane care of the mentally ill; and he asked only an opportunity to demonstrate the truth of his beliefs which were founded upon long experience and deep understanding. That his efforts were productive of a therapeutic advance is apparent in this book. The administrative officers of the Bureau of Medicine and Surgery and the hospitals were understanding and cooperative, as were all of the personnel who crossed Doctor Wilmer's path. I was particularly pleased that Admiral Nimitz visited the therapeutic community; he dignified the effort by his presence, and his interest bolstered the morale of all concerned.

As to the future of these therapeutic communities—it rests in the hands of dedicated men in and out of military service. The experiences gained in Doctor Wilmer's community can easily be translated into a civilian setting and they should prove of inestimable value in the treatment of what has been called "an illness most difficult to bear."

What will come of this work in the long run is for the psychiatric historian to report, but in the meanwhile I am proud that the Navy Medical Corps had an important part in its launching

and pleased to note that this dedicated and humane effort by Doctor Wilmer and his associates is in the great tradition of the Corps.

REAR ADM. B. W. HOGAN, M.C., U.S.N.
The Surgeon General
United States Navy



SURGEON GENERAL BARTHOLOMEW HOGAN

INTRODUCTION

In presenting this book to the reader I should perhaps first give some background facts about myself that have particular relevance to the experiment in social psychiatry that it reports—the Oakland therapeutic community program. I am a psychiatrist, trained in psychoanalysis. Though the program was not itself conducted as psychanalysis, the analyst's understanding of the unconscious processes inevitably influenced my approach.

At the beginning of World War II, I was myself a patient for almost a year in a tuberculosis sanitarium. I do not recommend this way of going about the process of understanding human nature, but nevertheless the experience did give me valuable insight into the patients' world. It also undoubtedly stimulated my desire to attempt with psychiatric patients a modification of the group therapy that I had employed successfully with tubercular patients on my return to medical practice after my own hospitalization.

In 1955, soon after I began my 2-year tour of Navy duty, the Navy Department sent me to England, where I spoke on group therapy in tuberculosis and visited again, as I had five years earlier, Dr. Maxwell Jones at Belmont Hospital, Dr. T. F. Main at Cassel Hospital, and Dr. T. P. Rees at Warlingham Park Hospital, all just outside London. At this time, as on my previous visit, I strongly felt that the principles being employed at these institutions marked a change in the concept of mental care that would be significantly felt sooner or later in the medical community throughout the world.

On my return to the United States I was placed in charge of the psychiatric admission ward at the Naval Hospital at Oakland, California. It was here that I instituted and conducted the therapeutic community experiment that this book describes. I explained to the admission ward staff how I planned to adapt the therapeutic community ideas to our ward, and with no further

preliminary preparation the program was begun.

Later I was ordered to the Naval Medical Research Institute at the National Naval Medical Center, Bethesda, Maryland, to prepare a report on the project. The volume of data available for my purposes was almost overwhelming. From the first day of the experiment I had made it a daily practice to write a full summary of each community meeting and each staff meeting. I had also kept a detailed diary in which I had entered the daily events on the ward and in the hospital and my analysis of them. These records filled over 4,000 typewritten pages, and there were over 3,000 pages of case histories besides. I had also kept all seating charts of the meetings, all notices posted on the bulletin board, all lists of requests for interviews, photostatic copies of suicidal notes—in fact, every scrap of paper that could conceivably be helpful in evaluating the experiment had been preserved. In addition, there were 133,000 feet of sound-motion films and tape recordings of all meetings for one month. During the 15 months which I spent at Bethesda these materials were painstakingly reviewed and analyzed. They form the documentary basis for the observations and conclusions which this book presents.

In presenting these observations and conclusions, however, I must emphasize that I make no claim to having innovated the ideas upon which the experiment was based. They have been borrowed from many people. The techniques employed were also borrowed, largely from Maxwell Jones, T. F. Main, and T. P. Rees, and modified to the special Navy hospital setting.

Nor do I claim to have established definitive conclusive results that can be measured and evaluated with scientific precision. It must be remembered that the ward on which the program was put into effect was first of all an operational part of a busy hospital. Patient care took precedence over all else; administrative responsibilities came next, and then research. Inevitably, with only one full-time psychiatrist on the ward, many research questions have been left unanswered.

The purpose of this book, therefore, is not to urge the Oakland program as a "model" for the mental hospital, but rather to report a scientific and human experiment as dispassionately as

possible, to define, classify, and describe, to isolate certain significant elements of the structure and process, and to subject them to such methods of evaluation as are on hand at this time. This is what was done, this is what happened, and this is how we conceived of what happened. Many of my inferences will surely turn out to be in error, but many will probably be valid. For the most part—since this was an operational, rather than a laboratory research project—I urge the reader to consider my findings as hunches. At this stage of psychology, sociology, and my own branch of medicine, and with the tools we had to work with, one could hardly ask for more. And this in itself was no small task.

ACKNOWLEDGMENTS

My indebtedness for help and encouragement on this study extends to very many people. I gratefully acknowledge my debt to them all in acknowledging my particularly heavy indebtedness to the following persons:

First and foremost, at all times I have had the complete and understanding support of The Surgeon General of the U. S. Navy, Rear Admiral Bartholomew W. Hogan, and of The Deputy Surgeon General, Rear Admiral Bruce Bradley.

The project was made possible by Captain George Raines, the Navy's Chief of Neuropsychiatry, who has shown a continuing interest in it and has in innumerable ways assisted it to its conclusion.

Dr. Francis J. Braceland, president of the American Psychiatric Association, Chief of Psychiatry in the Navy during World War II, and also my former chief at the Mayo Clinic, stood by me at all times and gave me valuable counsel and encouragement at a number of crucial moments.

Mention must also be made of the helpful interest shown by Fleet Admiral Chester Nimitz, who visited a community meeting on the ward.

In conducting the experiment itself, I was constantly fortified by the active good will and assistance given me by the administrative officers at the Oakland Hospital: most particularly Rear Admiral D. C. Gaede, now retired, who was Chief of Service at the time when the therapeutic community was instituted and without whose assistance there would have been no experiment; Captain Marion Roudebush, who later became Chief of Service; Rear Admiral J. Q. Owsley, Commanding Officer; and Captain A. C. Abernethy, Executive Officer. Captain John Nardini, the Chief of Neuropsychiatry at National Naval Medical Center, also visited our ward.

In addition, the Commander-in-Chief of the Pacific Fleet made

available for one month the services of the *Pacific Combat Camera Group*, under the direction of Chief Russell Kuhn.

The contributions of the corpsmen and nurses on the ward were very great, indeed, especially those of the nurse in charge, Lt. Bethel Greene, and the nursing supervisor for the psychiatric service, LCDR Lina Stearns. So also were the contributions of the clinical psychologist on the ward, Lt. Dennis Briggs, and the social worker, Mr. Joseph Concannon.

Many helpful observations were made for my guidance by the consultants on the project: Dr. William G. Barrett, president of the American Psychoanalytic Association; Dr. Emmy Sylvester; Dr. Karl Bowman; Dr. Jurgen Ruesch; and Mr. Gregory Bateson. (Evaluations of the program by Mr. Bateson and Dr. Barrett are presented in Appendix C.) Mrs. Lily Wegeforth and Mr. Joseph Parker made funds available for editorial help, and the Palo Alto Medical Research Foundation gave funds used for secretarial help.

I had the full cooperation of Captain O. E. Van Der Aue, Commanding Officer of the Institute, and Captain J. P. Pollard, its Executive Officer. Dr. John Hearon, Miss Dorothy Lathrop, Chief W. E. McLaughlin, and Chief C. E. Knight gave me invaluable aid on the statistical and graphic analysis of the project;¹ and my secretary, Mrs. Edith Pugh, performed a herculean task with great competence and unfailing good spirits. The American Psychiatric Association also helped me in various ways, and their contribution is gratefully acknowledged.

Dr. Maxwell Jones and Dr. T. F. Main have both given me generously of their time and knowledge in consultations over my text and data. But my debt to these two eminent British psychiatrists and to their distinguished colleague, Dr. T. P. Rees, goes much deeper even than this. The inspiration for undertaking the program at Oakland came from observing their work, and the techniques I employed were largely adaptations of those which they use in their outstandingly successful programs in England.

1. The full statistical and graphic analysis which, with the expert assistance of the Institute Staff, I prepared as basic background material on the Oakland experiment is far too extensive to be included in this book. However, it is to be published by the Navy as a separate report to the Naval Medical Research Institute under the title, *Practical Social Psychiatry*.

Finally, my thanks are due also to my publishers, Mr. Charles Thomas and Mr. Payne Thomas. As on previous occasions they have given me able and friendly assistance on all matters pertaining to the publication of the manuscript.

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H. A. W.

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SOCIAL PSYCHIATRY IN ACTION

. . . . You cannot get away from the accumulated suffering of mankind, or shake off the lesson that it should teach us.

And that lesson is that what goes on in my neighbor's house concerns me. If I let him go in need, I too may want. If he has an enemy, he will require me as a friend. If Nature is unkind to him, then I must be kinder. These are all simple things, known from time immemorial to any villager.

. . . . but a village, like a family house, still has a sacred place in the heart. Upon the level of this unit of humanity, we are successful You need not bleed in the streets of a foreign town to fight for it. You have but to rank it, neighborly, beside your own—your lilac-scented, gray-roofed New England village, your low, white-blazing desert hamlet of abode, your plain, straight-streeted, honest town in the corn lands or the cotton lands The people emerge as triumphant, and the people—even in streets with an ocean running down the middle—must recognize one another as neighbors.

DONALD C. PEATTIE

Immortal Village

CHAPTER I

SOCIAL PSYCHIATRY AND THE PROBLEM OF PATIENT MANAGEMENT IN THE MENTAL HOSPITAL

"The most important single factor in the efficacy of the treatment given in a mental hospital appears to be an intangible element which can only be described as its atmosphere. . . .

"Too many psychiatric hospitals give the impression of being an uneasy compromise between a general hospital and a prison . . . in fact the role they have to play is different from either: it is that of a therapeutic community."

—Expert Committee on Mental Health,
World Health Organization
Technical Report Series, Number 73

It is a truism, of course, that in the lives of all of us some incidents have had far-reaching influence on our later thinking and action out of all proportion to their importance in the sum total of our life experience. Such an incident occurred in my life some years ago when I was a comparatively young and inexperienced psychiatrist working at a large state mental hospital in the Midwest. One evening just at supper time I received an urgent call to the ward, where I found a patient lying on the floor unconscious, blue in the face, and gasping for breath. Two attendants were bending over him, and one of them told me, "He's choking on a piece of meat."

I tried by every means to dislodge the obstruction, but without success, and I saw that a tracheotomy would have to be performed at once. A surgical set could not be found; so with only a scalpel, on my knees by the light of a flashlight, I performed my first tracheotomy. But it was too late; the man died there on the floor of the ward.

As I stood beside the attendants over the limp dead body, the big gloomy ward stretched about me, with long rows of patients, some in restraints, sitting on benches lined against the wall, staring into space or silently, unemotionally watching. The moment had a bewildering, dream-like quality. Then a patient sitting near me said, slowly and in a melancholy tone, "It's been a long day for John Allen."

"Is that his name?" I asked.

"No," he replied, "I'm John Allen."

I walked away from the ward overwhelmed by the utter isolation of these patients, vacant-faced, forgotten, sitting like automata through their empty endless days. No one seemed to belong to anyone or even to be anyone. The experience has remained fresh in my memory and has colored my thinking on patient management in all the intervening years.

Another experience occurred a few years later at a rather expensive private sanitorium where I came to see a patient. As I was walking through the grounds, a desk lamp crashed through the glass panel of a door and fell at my feet. I walked over and looked through the broken panel into the room. There I saw four or five attendants beating a patient and forcing him to the floor, while a nurse and a psychiatrist stood by. The patient in terror kept screaming, "You're killing me!"

Sickened and enraged, I protested to the psychiatrist; and, as a result of my protest, I later received a letter from the medical director of the sanatorium saying that he was sorry I had seen (sic) this unfortunate incident. "But," he continued, "such things, as you know, are bound to happen from time to time in mental hospitals." It was my conviction that such things should never happen in mental hospitals, and I reported the matter to the state authorities in a detailed letter. But, of course, no sweeping reforms resulted. The attendants, in this hospital and elsewhere, were still hired without any preliminary training for their jobs and with no basic requirements established by state regulation to assure even their minimum fitness. They were still underpaid, and no more a part of the patient's day than was John Allen.

Over the years I realized increasingly that deadly isolation and brutality *are* both bound to happen under traditional mental

hospital practices of patient management and that they are also bound to have seriously antitherapeutic effects. I resolved long ago that if I ever had an opportunity to run any part of a hospital, neither would have any place in it.

A way by which they could be avoided with considerable therapeutic gain was made clear to me by visits to the therapeutic communities conducted by Dr. Maxwell Jones at Belmont Hospital, Dr. T. P. Rees at Warlingham Park Hospital, and Dr. T. F. Main at Cassel Hospital.

The opportunity came when, on my tour of Navy duty, I was placed in charge of the admission ward of the psychiatric treatment center at the U. S. Naval Hospital, Oakland, California. During the 10-month period that I was officer-in-charge (July 1955 - April 1956), the admission ward was operated as a therapeutic community. This book is a report on the program administered and the results observed in this setting.

The reason for reporting the Oakland program, however, is not only a "humanitarian" reason, though the humanitarian aspects of the program are apparent. It is also to suggest that the therapeutic community plan offers practical aid in solving a critical problem of our time—the problem of staff shortages in mental hospitals—with probably considerable therapeutic benefit to the patient.

THE CONTEMPORARY MENTAL HOSPITAL PICTURE IN GENERAL

Statistics on the incidence and cost of mental illness are almost too well known to warrant repeating. Over half of the hospital beds in the United States today are filled by mental patients, and, on the basis of present admission rates, one out of every ten persons will spend some part of his life in a mental hospital.

In 1955 the cost in public funds of caring for our mentally ill in local, state, and federal institutions amounted to over one billion dollars; and this figure rises to approximately 3.5 billion dollars if such factors are included as construction costs for new mental hospitals, loss of patients' earning power, and loss of income tax revenues.

The grave shortage of trained psychiatric personnel with which

to meet the mental hospital problem has been well documented. The Commission on Organization of the Executive Branch of the Government, in its report on mobilization and health power, expresses the opinion that lack of trained personnel—physicians, nurses, and other adequately equipped professional and auxiliary workers—is the most serious present hindrance to the proper care of the mentally ill. In terms of the minimal standards set by the American Psychiatric Association, the average state mental hospital today is understaffed by 40 percent in physicians, 66 percent in registered nurses, 28 percent in attendants, 75 percent in social workers, and 76 percent in clinical psychologists.

Present requirements for psychiatrists are estimated at 20,000. There are at present around 10,000 members of the American Psychiatric Association (including Canada), and the profession's net gain in numbers is approximately 400 per year. At this rate, it will take 20 years to meet present requirements, and the population on which these requirements are based will have greatly increased by then.

The Mental Hospital Picture in the Navy

Orientation to the problem of patient management in the experiment to be described here requires some examination of the mental health problem in the Navy.

During the 1954-55 period over 3 million sick days were attributable to psychiatric illness in the Navy as a whole. Whether this figure is considered in terms of dollars, human suffering, or military efficiency, the cost is astronomical.

In 1955 alone, 9,341 Navy personnel were hospitalized for psychiatric reasons, the accumulated periods of hospitalization amounting to 432,896 days. In terms of diagnostic categories, the figure on sick days breaks down as follows: psychotic disorders—114,501 (86.4 days per patient); psychoneurotic disorders—130,074 (44.3 days per patient); character and personality disorders—174,308 (38.7 days per patient); disorders of intelligence—1,993; transient personality disorders—12,020. The average hospital stay per patient was 46.3 days.

The maintenance cost of medical treatment facilities in the U.S. Navy for 1955 was \$40,597,510.00. Only one diagnostic group

—accidents, violence, and poisoning—exceeded psychiatric disorders in *total sick days* amassed. Mental disorders accounted for more than 33½ percent of the separations from the service in the medical department—over one-third of all patients transferred to Veterans Administration hospitals for extended care.

TABLE I

VOLUME OF NEUROPSYCHIATRIC SERVICES AT U. S. NAVAL HOSPITALS:
MEAN MONTHLY FIGURES FOR CALENDAR YEAR 1955¹

<i>U. S. Naval Hospitals</i>	<i>Bed Census (monthly mean)</i>	<i>Admissions² (monthly mean)</i>	<i>Consultations (monthly mean)</i>
I. Psychiatric Treatment Centers:			
1. Oakland	239	98	501
2. Philadelphia	218	79	125
II. West Coast Hospitals:			
3. San Diego	113	95	374
4. Oceanside	72	49	124
5. Corona	39	24	185
6. Mare Island (near San Francisco)	33	31	31
7. Bremerton	13	19	86
III. Pacific Area Hospitals:			
8. Yokosuka	49	89	377
9. Tripler 3	43	43	392
10. Guam	10	8	111
IV. Other Major Continental Hospitals:			
11. Bethesda	91	41	345
12. Portsmouth, Va.	100	79	245
13. Camp Lejeune	72	83	143
V. Total psychiatric services: All above hospitals and 15 others	1,397	985	4,510

1. From Monthly Summary Figures, Bureau of Medicine and Surgery.

2. Includes neurologic cases in some hospitals.

3. U. S. Naval Medical Unit, Tripler Army Hospital.

Yet these figures represent an improvement over earlier years, largely as a result of better screening of recruits. From 1951 to 1955 the rate of discharge for psychiatric unsuitability at recruit training stations more than doubled (from 14 to 37 per 100). This increase was paralleled by a substantial decrease in psychiatric incidence, noneffectiveness, and invaliding. In 1955, as compared with 1951, the psychiatric incidence rate per 100,000 average strength dropped from 1,394 to 1,055; the rate on sick days from 252 to 134; and the invaliding rate from 829 to 481.

But still the hospital and service burden remains enormous.¹ The Navy maintains two psychiatric treatment centers (Oakland and Philadelphia) and provides psychiatric services at 26 other Navy hospitals. During 1955 the average number of beds in all these installations combined was 1,397 per month, and admissions averaged 985 per month. The number of consultations with patients averaged 4,510 per month, or 4½ per patient admitted. (See Table I.)

The number of psychiatrists on active Navy duty during 1955 averaged 149 per month (4.4 percent of the 3,410 medical officer total). As compared with 31.9 percent of all medical officers, 65.1 percent of the psychiatrists were assigned to Naval hospitals.²

SOCIAL PSYCHIATRY AS AN APPROACH TO THE MENTAL HOSPITAL PROBLEM

Undoubtedly there is a serious problem of staff shortages in mental hospitals today, and the supply of trained psychiatric

1. It is obvious that any modifications undertaken to decrease the social, human, and economic burden which these figures reflect would need careful consideration. A wide use of the therapeutic community plan of hospital management would, I believe, be a beneficial modification that would result in returning more men to duty and shortening hospital stay. But there is even more urgent need to extend psychiatric services into the field, to increase facilities and personnel devoted to preventing the need for hospitalization. Probably also an advantageous modification would be to assign a well-trained psychiatrist of high rank as area or fleet psychiatrist to work with commands in planning and organizing services and to ameliorate situations such as we observed where certain ships or certain areas seem to account for a disproportionately large number of psychiatric casualties.

2. The remaining assignments were distributed as follows: Naval training commands—10.7 percent; Marine Corps activities—9.4 percent; retraining commands—4.7 percent; other activities—10.1 percent.

workers is not likely to increase spectacularly in the years immediately ahead. In view of this situation, new methods of patient management must obviously be found that will narrow the gap between staff requirements and supply by increasing the effectiveness of the existing staff. One such method is the therapeutic community technique of social psychiatry,³ which, by bringing the patients into cooperation with the staff and with each other on problems of ward management, helps fill the gap while it also opens up new possibilities for therapy through social interactions. Wide use of this plan, I believe, would significantly help in solving the problem which otherwise, with the staff functioning in traditional roles, seems hopeless of solution.

The therapeutic community concept is not new in the history of mental treatment. But it began to be subjected to scientific scrutiny during and after World War II, especially in England, following upon the work at the Northfield Military Hospital.

In the therapeutic community the hospital is conceptualized literally as a form of community, of both patients and staff, and its pattern of life is designed to create an environment—a milieu—that reproduces as nearly as possible the types of interpersonal communication and action that exist in the outside world from which the patient has come and to which it is hoped he will be able to return as a useful member. Staff-patient and patient-patient relations take their form, like the relations of persons in the outside world, from common membership in the social group and the mutual responsibility that attends this membership. Lines

3. "Social psychology is the scientific study of experience and behavior of individuals in relation to social stimulus situations. Social stimulus situations are composed of people (individuals and groups) and items of the sociocultural setting." (Sherif and Sherif)

Social stimulus situations can be classified under the broad headings of other people and cultural products. Social psychology is an area which the psychologist, sociologist, anthropologist, ethnologist, and behavioral scientists explore in the laboratory or the field.

Social psychiatry is an area where physicians—qualified as trained psychiatrists—utilize selected contributions of social psychology, medicine, and psychiatry in the prevention and treatment of emotional and mental illness; in the rehabilitation, socialization, and acculturation of the sick, from any cause whatsoever; in the scientific study of etiologies, hypotheses, theories, and treatment concepts (which consider social, cultural and environmental factors) under field or operating conditions with the collaboration of their colleagues.

of communication are relatively free, and the community is given access to relevant information on the problems it jointly meets. The major formal device employed is the group meeting. Here, in an atmosphere of intimate, spontaneous, face-to-face interaction, both patients and staff can express their own feelings and needs, and hidden community tensions can be revealed and examined.

The manner in which socio-environmental and interpersonal influences play a part in the treatment programs in the therapeutic community is described by Maxwell Jones as follows: "It would seem that in some, if not all, psychiatric conditions there is much to be learned from observing the patient in a relatively ordinary and familiar social environment so that his usual ways of relating to other people, reaction to stress, and so on can be observed. If at the same time he can be made aware of the effect of his behavior on other people and helped to understand some of the motivations underlying his actions, the situation is potentially therapeutic. This we believe to be the distinctive quality of a therapeutic community. Clearly there is the possibility of any interpersonal relationship being therapeutic or antitherapeutic. It is the introduction of trained staff personnel into the group situation together with planned collaboration of patients and staff in most, if not all, aspects of the unit life which heightens the possibility of the social experience being therapeutic."

Roles and Relationships. The basic departure of the therapeutic community from traditional plans of mental hospital management stems from its different view of staff-patient roles and relationships. On the traditionally managed ward the role of the patient is to be sick. Staff attitudes are consequently based on the expectation of sick behavior. It is even possible that certain clinical syndromes or characteristic ways of behaving in a hospital environment are actually a response to this expectation.

In the therapeutic community, in contrast, the role assigned to the patient is that of a responsible member of a social group, and the expectation is that his behavior will conform as nearly as possible to the norms of society. It is assumed that even the patient who, on initial contact, might appear dangerous will often become actively uncontrolled only if the staff reenforce his dangerous potentialities by acting as if something terrible might

happen. Therefore, in the community, staff fears are not projected into staff-patient relationships. The expectation is, rather, that each member can and will exercise self-control, and staff attitudes toward patients are based on this expectation. As a result, procedures are designed to foster self-control, rather than to impose controls from without. The use of locks, mechanical restraints, seclusion, punishment, and suppression of ideas and feelings is abandoned whenever possible. Such methods defeat the therapeutic purpose of fostering the self-control on which acceptable modes of social behavior are based.

The new role which the therapeutic community assigns to the patient also necessitates a new role for the staff. In the conventional mental hospital organization, where their security lies in becoming rigid custodians, the staff may commonly be expected to treat their patients as things because they are also dehumanized units; that is to say, they are expected to achieve the impossible —to keep their temper with patients while getting little personal reward from their jobs.

But if they work in a humanized unit, where their seniors treat them as people, they no longer have the need to retreat into the isolated position of the disciplinarian. Their identification with an uncaring authority will be replaced by an identification with a caring authority. If their own emotions are tolerated in discussion, then their patients' emotions can be tolerated by them in discussion. If the leader cares, they care. (This fact may be particularly important in an organization such as the Navy, where leadership and identification with the leader are all-important.)

Discipline can be superego based (as are such notices as "Keep off the grass") or ego based (as, for example, in the rule of keeping to the right while driving along the road). Once the staff themselves are subject to ego-based discipline, they in turn offer ego-based discipline to the patients. Psychopathologically, I think this is because of mechanisms of introjection and projection. If they are forced by their superior to introject his guilt and contempt, they will in turn project it onto the patient. If they themselves can be helped to tolerate their own internal disorder without being made to feel guilty and contemptuous, they will not project their own feelings of internal disorder, allied with guilt

and contempt, onto the patients. The treatment of the staff, therefore, is all important. All this adds up to the fact that a therapeutic community is, first of all, therapeutic for the staff. The game of hunting the bad in an institution and finding it variously in the patients, in the junior staff, in the senior staff, is replaced by a process of seeking and finding the bad in oneself and thus denying oneself the luxury of the projecting techniques.

The creation of an atmosphere in which there is benign toleration of the bad and promotion of the good is primarily the responsibility of the psychiatrist. It is at the senior levels of the hospital, in the nuclear command, that such an atmosphere is generated. The dilemma for all administrators lies in creating a rigid, effective, executive chain line of responsibility devolvement and at the same time offering real roles to real people in such a structure. The problem for administrative psychiatry is just this—how to maintain an efficient executive chain and at the same time allow the staff to think and to feel themselves to be human beings rather than units. (This, of course, is the same dilemma as faces all industrial, military, and political administrators.) I think the solution lies in clear definition of the social structure, coupled with regular group meetings of all those concerned, so that the purpose and method of the social structure can be understood by all to be an efficient, human organization, rather than a rigidly inhuman piece of unnecessary machinery, harsh, purposeless, or ill understood.

Social Structure in the Therapeutic Community. A therapeutic community is one which has the declared purpose of being therapeutic for its members individually and collectively. This simple statement takes on significance once it is granted that the membership of the hospital community includes not only patients, but staff, with rights co-equal with patients to receive benefit from the community and to join with them in owning feelings and needs, in laying bare and examining hidden community tensions, in fostering and maintaining optimal relations with others, and in formulating codes and procedures and bearing responsibility for carrying these out.

The fact that both staff and patients may be granted co-equal rights as human beings in such a community in no way implies

co-equal function or role status. It cannot; for hospitals are not democracies run by elected representatives of the community, but hierarchies whose senior members are appointed to their roles of authority by extra-hospital super-authorities and who carry inescapable responsibility to these super-authorities for the total work of the community. Authority in the hospital is therefore both necessary and inescapable. Although powers and responsibilities may be delegated for operational purposes to other members of the community engaged for such purpose, there can never be final renunciation of responsibility by the hierarchy. No amount of permissiveness, group discussion, consensus-seeking, joint consultation, or freedom of expression can obscure this fact. Authoritarianism, an emotionally determined method of exercising authority, is one thing; it crushes by penalties all opinions save that of the one, ignores the feelings, wishes, and judgments of subordinates, yet demands obedience and conformance to an ideal of goals, tasks, and method decided by the senior authority, with rewards and punishments following automatically and without exception. But *authority* is another matter; it implies responsibility accompanied by sufficient power to discharge it.

It is *the way in which authority is used* that distinguishes the therapeutic community. Here the person in authority makes an inexorable demand of an unusual order, which is this: while he is ready to lend the community his professional skills, the community is not to expect him to solve by administrative fiat, *ex cathedra* pronouncements, or punitive disciplinary measures those of its problems which are created for it by its own unruly members; instead, it should join with him in regular discussions to identify and clarify such problems, to lay bare the nature of the tensions both personal and interpersonal that give rise to these problems, and to decide if and how these can be modified; and in all this the authority demands for himself, his staff, and his patients, not co-equality of power or responsibility or role-status, but co-equality of human rights in such matters as opinion, feeling, and need. These authoritative demands are neither small nor few, and are no simple matter for staff.

With a well-ordered society which has the sole aim of keeping the status quo, as with a well-functioning personal super-ego in a

single individual, a great deal of immediate mental economy is achieved; traditional solutions are automatically and unthinkingly applied to the problems of living and feeling; disorder (anxiety, doubt, worry, and disturbance) is avoided by the application of these solutions and peace is maintained. Badly disturbing elements are banished, walled-off, attacked, deadened or drugged into silence; the problem they present is disowned and there is little anxiety.

This method of dealing with problems, either by an individual or by a society, has, however, certain disadvantages. The disturbing elements are deadened but not killed by such treatment, and the problems created by them need the continued maintenance of suppressive and repressive measures, chemical, physical, or emotional, perhaps with increased ferocity as need arises, if peace is to be preserved for the remainder. Sometimes this method leads to a situation where so much of the energy of the respective individual or society is required to maintain order that there is little to spare for any other activity. No state where too much of the citizens' time is taken up by police activities is using its resources well. Nevertheless this method is, in the short run, economical of effort, thought, and anxiety by the management. It is "safe and sure" but not very productive.

Another method of dealing with a disturbance by frightening, disturbing, or intolerable elements is to avoid the application of automatic tradition-hallowed solutions and to undertake the work of thinking out for each instance the solution which will produce the least tension-full situation for all. This requires the recognition by all of the legitimate needs of each. This method of dealing with problems, by contrast with the first, is neither simple nor automatic; it requires the toleration of strain and anxiety while the solution is being sought by hard mental work, and it is expensive of effort because a fresh solution has to be worked out for each problem that arises. It is never-ending and on-going; and although it does not consume the energy of the community in maintaining impositions, it cannot be rated as simple, easily applied, or economical of thought. Its merit lies in the fact that by permitting expression of individual specific judgments and providing guidance of a thoughtful order for all,

it makes not for strained peace, but for more or less optimal relations with more or less harmony, full freedom of action to none, but some satisfaction to all. This type of management is suitable for certain social disturbances and situations; psychiatric illness appears to be one.

In a hospital this method requires of the staff a capacity to tolerate their own anxiety in the face of disorder in a patient, and not to seek to crush the disorder, but rather to explore fully *together with other members of the community* (each other and the patients) the nature of the problem it presents for all, to expose the echo it creates in their relations with each other and thus to help the community (including the staff) to increased awareness, not only of points of view of its members, but of the nature of the problems it faces. This increased awareness can now lead to actions based on the authority of knowledge, and on concern rather than fear and intolerance.

The first type of solution gives great security to the staff. It is true that when roles within the hierarchy are rigid the staff have little need for personal thought and initiative, but the staff know where they are; their tasks, though narrow, are defined clearly and they can use solutions to problems in their work ready-made by those set above them. The untoward wishes of those below them in the hierarchy—the patients—are not very important except to be noted rather as is clinical behavior. The patients have to fit the system, somewhat as things, and the staff behaves as if it is there to treat a half-thing—a patient—rather than a living creature of the same order as themselves. (Informally, and informally sanctioned, the staff may frequently make human contact with their patients, but this is not clearly within their professional role. It is regarded as wise and humane but not inherently a professional technique.) The staff is thus secure and assured, somewhat dehumanized, but it can work together in disciplined and fairly effortless fashion. It handles somewhat dehumanized patients, but can keep the peace by its strength, authority, and by its authoritative treatments, which vary from medical treatments to disciplinary measures.

The second type of solution gives the staff no security of this kind, but it offers compensatory satisfactions. They need no

longer behave automatically but have a right to discuss their views and feelings in daily meetings with patients and other staff. Their personal viewpoints are no longer matters to be concealed behind a professional role, but are legitimate human property. In these daily meetings they have the right to feel, to contribute and argue a viewpoint, and to expect it to be regarded as a significant element in the community's emotional and intellectual wealth. They can air views, extend comfort, praise, criticism to their fellows openly and without hiding these behind a facade of professional propriety, charity, discipline, and other forms of strainful virtue. They can in turn obtain support or discipline for their views and the testing of social reality for their feelings by staff discussions and community meetings. Their own difficulties with patients are not viewed in this system as matters of incompetence on their part or of blame for the patient but of daily study by them and others. They can become alive and so utilize and make fruitful their human resources in staff discussions.

Participation in the thinking-through of staff policies not only allows all to bear better the frustration of impulses demanded by daily work but actually to enjoy the capacity to bear strain in the service of a community policy and to share their achievement with a team. They do indeed move from a situation of being minor executives of a policy decided from above, to one where they can daily contribute to the policy and be disciplined by a living on-going process.

The freedom of discussion in the community or staff meetings should not be confused with the situation outside these discussions, which contains clear staff roles, allotted tasks and duties, and defined powers and responsibilities for all. Now the community has to go about its domestic tasks according to the policies already formed. It is true that the way in which these tasks will be performed may have been much modified by community and staff discussions; but between discussions the individual, staff or patient, bears responsibility for tasks which he cannot escape. His difficulties and triumphs he can share tomorrow with others, but for the time being he must do the best he can to fulfill his function. On the other hand he can know that he will be

supported in his tasks by the community to which he belongs and which in part belongs to him.

In community and staff discussions in the therapeutic community the staff member who handles patients achieves a new importance derived now not only from his staff role but from the human resources within him. His identification with the purposes of authority now leads to the work-a-day ethic that just as he is allowed his feelings and thoughts as important contributions so he will allow feelings and thoughts to his patients. His patients in turn can relate to him *as a human being* for he is no longer merely the representative of an authority system.

The point can hardly be made too strongly that before the staff can accord the patients the right to have their feelings tolerated and puzzled over with sympathy and ego-based discipline, they themselves must have had the experience of working alongside staff authorities who accord this right not only to patients but to them. All this adds up to the single axiom that a therapeutic community is therapeutic in the first place for the staff. The on-going experience of having their own work-day experiences, doubts, anxieties and opinions tolerated, valued, and worked over in daily staff group discussions about their community leads in them to fruitful exercise of their human resources and to a discipline based on social reality directed towards a task, the rescue of their patients from retreat from reality. The very atmosphere of the community springs in the first place from the staff, and it is in the handling of their potential that the authority of the therapeutic community is on test.

THE OAKLAND THERAPEUTIC COMMUNITY EXPERIMENT

The therapeutic community technique is not proposed here as a panacea for all the ills that beset the mental hospital. Its use at Oakland, however, was indisputably an effective aid in patient management. The program at Oakland was conducted on a busy admission ward which had previously been managed by conventional hospital practices employing restraints, large amounts of sedation, and seclusion as methods of control. Such methods were discontinued. Yet behavior improved dramatically.

Serious violence disappeared entirely. This does not mean that no blows were struck by any patient in the therapeutic community, for sometimes it became temporarily impossible for a disturbed patient to control himself. But such episodes were of short duration and were modified by the community itself.

Since our patients remained on the ward only while awaiting transfer to the wards where intensive therapy was to be given, no pretense at enduring cures is of course entertained. But that the social process exerted a powerful force in modifying symptoms, as well as in controlling behavior, will be documented. (Naturally long-term critical follow-up in controlled similar experiments is essential for the evaluation of this type of work.)

The program was administered with the aid of an unselected staff, assigned in normal rotation to the ward without preliminary indoctrination or training and in no greater number than previously.

After an initial period of apprehension at no longer being able to employ the customary devices by which patients are managed in the conventional hospital, the staff found the new methods of dealing with patients more challenging and more satisfying than the old. There was far less staff frustration and discouragement and far more interest in caring for the patients. For practical purposes, the rigid 8-hour culture quietly went out of existence on the ward. The staff stayed beyond working hours entirely on their own initiative if the needs of the patients required it, although this was not frequent. The best human qualities of the staff emerged for the benefit of all when their relationship to the patients was conceived of in different terms than custodial, and mutual trust and respect between patients and staff replaced fear.

No attempt was made to separate completely administrative and therapeutic roles of the ward psychiatrist. But the program greatly simplified administration of the ward and therapy was made available to all in an unconventional method of management.

The setting of the Oakland program, it is true, was a very special one—the admission ward of a Navy psychiatric treatment center. All of the patients were male; most of them were young and most of them were in their first major illness; all of them,

and also the staff, belonged to a military service and thus shared a common culture. The situation, therefore, cannot be considered a representative mental hospital situation in these respects. Yet in some important respects it was quite representative. Like most mental institutions we had to deal with large numbers of patients without a large staff of trained professional workers. Like the state hospital, in particular, we also had to accept all patients sent to us; there was no opportunity to transfer them to another institution for any reason whatsoever. Almost half the patients with whom we dealt were psychotics (44.4 percent), and many of them were very sick.

With variations and adaptations to particular cultural situations in particular patient samples, therefore, the method employed at Oakland might serve as a plan for other mental hospitals faced with similar problems.

Control in the Oakland Therapeutic Community

In any mental hospital "control" is an essential factor in the care of patients. Indeed the mental hospital's very existence is predicated on society's need to establish control over its sick members as a safeguard both to itself and to them. The question then is not whether control should be established, but what form it should take—whether it should be mainly imposed from without or fostered within the patient himself.

The ultimate objective of the therapeutic community is self-control, rather than imposed control, and the technique employed for attaining this objective is a technique of social readjustment and acculturation. The underlying philosophy is that the social process is capable both of modifying behavior and effecting clinical improvement by giving the patient the incentive to control himself and by developing his ability to do so.

Yet without some outer controls, without clearly and consistently set "limits," without the tools of the trade known as therapy (whatever variety), self-control cannot be realized in the acutely ill mental state.

In the Oakland therapeutic community we totally discarded the conventional hospital controls of mechanical restraints and seclusion rooms, and we made only negligible use of barbiturates.

But our controls were several:

- (1) The outer door of the ward was locked.⁴
- (2) The most hyperactive psychotic patients were given ataractic drugs.
- (3) The staff served as a humane and human control.
- (4) Daily community meetings of patients and staff (a variety of group therapy) exercised a real social control. Even the sickest patients were expected to sit and behave and if possible talk in the meetings.
- (5) Daily staff meetings served to relieve staff anxiety and fear and to give deeper understanding of how the patients' self-control could be fostered by the staff during the important other 23 hours of the day on the ward.
- (6) The military culture, of which staff and patients alike were a part, fostered an *esprit de corps* that was utilized as an influence for self-control.
- (7) The availability of the doctor to all patients for individual interviews upon their written request created a spirit of cooperation and self-observation that stimulated efforts at self-control.
- (8) Finally, and perhaps most important, was the staff's manifest expectation of appropriate behavior and self-control on the

4. While it was obvious to me that the ward could have been operated unlocked under the existing conditions, there was no clear reason to make a revolutionary change in established Naval policy in this regard. For purposes of the experiment, in fact, it was felt undesirable to set up too exceptional a situation, for no matter how successful it might have been, its results would have carried less conviction. Moreover, had we operated on an open receiving ward, we might have felt pressure to transfer very psychotic patients to the closed wards, particularly patients given to wandering off the ward. The very strength of the hypotheses drawn from our observations rests on the fact that patients were *not* transferred to other wards because they were unmanageable in the therapeutic community. Another reason why the change was considered inadvisable was that, since there were still other locked psychiatric wards in the hospital, it would have been confusing for patients to be transferred from an unlocked admission ward to a locked treatment ward as they "progressed" in their hospital care. But, most important, it was not the freedom of the unlocked door but the freedom of spirit and the milieu behind the locked door that mattered.

The 'open door' is a current trend related to wider developments. How it is used is what matters; it is not in itself good. It is not new. In 1873 two mental hospitals in Scotland had a reputation for their open door policies, and the annual report of the Scottish Board of Control (1881) made a plea for more active use of the open door system by mental hospitals, but by 1890 no further mention was made.

part of the patients. Patients not only sensed that they were expected to have self-control; they were indeed often told so.

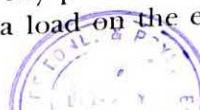
But they could see from the operation of the ward what was never put into words to them: Patients had a right to dignity and self-respect, and this right would never be violated in patient-staff relationships on the ward. Their welfare was the paramount consideration.

As this report will make clear, the history of the ward was not without critical times. There were belligerent and hostile patients, and there was angry and bizarre behavior. The crucial point, however, is that a milieu was created that permitted recovery, rather than driving patients deeper into insanity as, unfortunately, conventional hospital practices frequently do. Our patients were treated as normal people who were sick, but whose human right to dignity and self-respect was in no way impaired by their sickness.

The therapeutic community is a far cry from being repressive therapy in any authoritarian sense. (On the other hand, no attempt was made to separate rational authority from psychotherapy.) But this form of treatment does help to bring about successful repression, which in a sense is the goal of psychological treatment. The goal of analysis is, of course, to reduce the load of repressions by bringing into consciousness the material behind certain childhood repressions and then making those repressions unnecessary.

In a sense, the therapeutic community also fosters repression and suppression, for from one point of view all adaptation requires repression of certain impulses, and inhibitions are a necessary part of social life. But the conditions which bring it about in the therapeutic community are totally unlike the traditional repressive and suppressive measures of psychiatry. Our results in modifying patients' behavior can be attributed largely to social forces. The type of confrontation with reality which the community affords and the necessary anxiety attendant upon it do not favor fantasy play with the object of disclosing deep conflict areas and interpreting them. What we tried to do was to bring some things into the open, offer relatively free channels of communication, and thereby permit the maintenance of other repressions without too big a load on the ego.

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Date 20.9.62



CHAPTER II

THE OAKLAND ADMISSION WARD AND ITS SOCIETY

*Sapius est initium mederi, quam fini.**

The Adagia of Erasmus

The admission ward at Oakland was a 34-bed locked ward. The building itself was a frame structure of the temporary type that was rapidly built for military use early in World War II. In contrast to a few elaborate mental hospitals it was a poor, poor cousin. But it always seemed an adequate physical plant and indeed quite a desirable one for the sort of study we chose to conduct. At no time did we wish to transport our patients to elaborate wards. There was a homely feeling about the place as if it was not too far from whence they had come and not too far from where they were going.

At times there were serious shortages of corpsmen and nurses and, while at some periods I had the assistance of an intern or resident, for the most part I was the only physician on the ward.

There were frustrating times too when for months, for example, we had only hopelessly dilapidated athletic equipment because there were no hospital funds with which to buy new. Difficulties of this type sometimes posed serious hardships, but they were not insurmountable ones. After all, in a ship at sea the crew faces the sea and the winds as they come, favorable or unfavorable. So did we in the therapeutic community. Frustrations were part of the reality situation that the patients had to learn to face and, if necessary, to accept. Such problems were dealt with in the community meetings with sometimes an appropriate show of resentment, but without any unmanageable degree of it.

THE PATIENT SAMPLE

During the 10-month period of the experiment, 939 patients

* It is better to doctor in the beginning than at the end.

were admitted to the ward from the area which the Oakland psychiatric treatment center serves — the West Coast Naval and Marine installations, the Pacific fleet and islands in the Pacific, and U. S. Naval hospitals on the West Coast and in the Far East.

The diagnostic breakdown of the group was as follows: Psychotics — 44.4 percent (of whom 91 percent were schizophrenics); psychoneurotics — 26.6 percent; patients with character and personality disorders — 28.3 percent (Graph 1, Appendix D). Patients suffering from acute situational maladjustment comprised the remaining 0.7 percent. All diagnoses reported in this book are those following completion of psychiatric evaluation.

A detailed statistical study of a smaller sample of 576 cases revealed the following additional facts: Navy personnel made up 68.8 percent of the sample and Marine Corps personnel 31.2 percent. In terms of the duty stations from which the men had first been admitted to the sick list, 18.2 percent had come from shore duty within the continental United States, 33.9 percent from sea duty, and 47.9 percent from foreign shore duty. The proportion of officers in the group was 3.5 percent; the remainder were enlisted men (rated and nonrated) and noncommissioned officers. The median length of service was 3 years. In marital status, 64.3 percent of the group were single, 30.9 percent married, and the rest separated or divorced. Suicidal attempts had been made by 11.9 percent of the patients immediately prior to their hospitalization.

At the end of their stay at Oakland, 82.8 percent of the patients were separated from the military service; 14.4 percent were returned to full duty and 2.8 percent to 6 months limited duty as a sort of trial test of their recovery. Approximately one-third of the group were still considered 100 percent disabled and eligible for Veterans Administration Hospital care.

The Psychotic Sample. In comparing the psychotic sample with other schizophrenic samples, the fact that it is weighted in a certain manner should be kept in mind:

- (1) All the patients were males.
- (2) All had been selected for a military service either voluntarily or through the draft (or the pressure of the draft).
- (3) All had been screened for physical and emotional defects

at induction centers. Though the psychiatric screening was variable, the sample nevertheless represents a cross section of "healthy young American males."

(4) They had recently experienced a new type of training and social experience under relatively uniform conditions as to age, diet, and living conditions.

(5) Except in a few instances of fraudulent enlistment, all were experiencing their first recognized psychotic break. (This fact may give the Oakland experiment special significance in evaluating the uses of the therapeutic community technique. Numerous group therapy projects have been concerned primarily with the treatment, rehabilitation, and socialization of the chronic, long-time mental patient. The highly crucial early period of hospitalization with which this study deals has hitherto been a somewhat neglected area.)

(6) Many had had difficulty adjusting to the conditions of military life — life aboard ship, life on the Pacific Islands with cultural conflicts, separation from home, et cetera. Thus a certain number had rapid spontaneous remissions when removed from their stressful situations.

(7) An acute schizophrenic break in a military organization is often less malignant than the breaks ordinarily seen in civilian psychiatric hospitals. One reason for this is that similar psychotic breaks might have gone unrecognized and untreated in civilian life, where medical care would not have been mandatory. From a management point of view, however, many of these transient acute psychotic breaks were more extreme and were accompanied by greater excitement than the more slowly evolving and malignant chronic varieties.

(8) Comparison of this sample (or of the neurotic sample) with *wartime* psychotic (or neurotic) samples should be made with great circumspection. The catastrophic effect of the continuing reality is a different order of thing, though related.

Types of Illnesses in the Patient Sample. The admixture on the ward of various types of mental illnesses is shown in Graphs I and 2 (Appendix D), based on the 576 representative cases that were subjected to detailed statistical analysis.

The problems to be encountered with the psychotics and the

neurotics could be anticipated from past experience; and the problems with the "psychopaths" could be anticipated from Maxwell Jones' experience with them in the therapeutic community. But the admixture of the three in one group would create special problems, particularly because of the character disorder patients.

Certain problems we anticipated:

(1) The character and personality disorder patients, particularly the aggressive and the passive-aggressive ones, would be provoking to the staff and to certain psychotic and psychoneurotic patients, especially the immature, the latent homosexuals, and the less aggressive psychotics. They would attempt to manipulate staff and patients and would have a conscious or unconscious desire to "make them perform" as they expected; they would exacerbate the symptoms of patients whom they were able to disturb.

(2) The passive-dependent, the inadequate, the schizoid, and the emotionally unstable patients would run the risk of becoming sicker, at least socially and symptomatically, in the intimate locked-ward association with the more aggressive character disorder patients and the schizophrenics who manifested the more frightening types of psychotic symptoms.

(3) The character and personality disorder patients as a group would be unwilling to accept their status as mental patients and the locked ward, and would attempt to use the community as a device for retaliating against the Navy in general and against society for maltreatment, both real and fantasied, that had aroused their resentment and hostility. Their suspiciousness and underlying paranoid ideas would lead them to doubt the sincerity of the staff, and this doubt would be overcome only by experience on the ward. (For them particularly "seeing is believing.") Many in disciplinary status awaiting brig sentence would feel doubly punished by being marked as "psycho."

But the therapeutic community functioned admirably with this group, and some of them showed an amazing degree of sophistication, dignity, and desire to help each other. While this was observed with only a portion of the character disorder patients — for, after all, they were only on the ward for about a week and

a half — the fact that social improvement did occur with some had a dramatic effect on the other "psychopaths" for their ranks were broken. Repeatedly it was observed that the psychopathic clique with its contempt for others, its effort to manipulate, to disrupt and fragment the community, lost its punch when one or more of its members fell away and openly or tacitly joined the group. This happened without any show of rejoicing by the staff or interpretation to the group. They would see that the staff disapproved of their behavior but did not despise them because of it. They were not punished but welcomed in a friendly, firm, and consistent manner, although limits were set on how they could behave in the community. Unprepared for this attitude from their past social experience, they occasionally became depressed, fell into a sort of quietness and believing-disbelief long enough for them to disarm themselves and for other patients to manifest warmth and interest.

The more hostile, threatening, aggressive character disorder patients found themselves not only without an ally but openly questioned and disapproved by the group, and where, under less controlled circumstances, overt or subtle retaliation would have been possible, they lacked the courage or the ability to confront these people in open defiance. Moreover, they found that the "legitimate gripes" about the Navy met a sympathetic audience while their more global hostility was either silently or verbally rejected.

To their surprise an *esprit de corps* actually existed in a mental hospital ward where belonging in a deeper sense was important. On some occasions in meetings their venomous attacks on the service were met by a testimonial type of response in praise of the Medical Department or the Navy, especially by older rated enlisted men, chiefs, sergeants, and officer patients, who enjoyed a certain status on the ward.

They knew where they stood and what they could expect at the hands of the staff. They knew that like others they would, if necessary, be protected from unwarranted hostile attacks and, above all, they knew that "the doctor knew" and at least partially understood their plight and accepted it as an illness.

Moreover, they saw desperately psychotic patients improve and

even relinquish or change their symptoms, just as the others saw the "bad men" become tractable. It was this quick tempo of change, occurring often enough to be in the memory of at least some members of the community at all times, which gave a special tone of hopefulness and interest to the meetings and to life on the ward. A situation existed where the "outsider" was the person who himself closed the door.

An element of surprise also favored us for the "psychopath" was taken aback by his care. He did not believe that the quiet room was not used; he mistrusted us and expected punishment. When his disbelief was shaken he sometimes reacted *as if* this were the way he had secretly hoped to be treated. Thus he found dignity in a situation where he had expected only greater humiliation. Being was belonging.

ADMISSIONS AND TRANSFERS: THE CHANGING SOCIETY ON THE WARD

The daily variations in the number of admissions are shown for a full 8-month period in Graph 3, and the day-by-day transfers are shown for 4 months in Graph 4 (Appendix D). The stay on the ward was arbitrarily set at 10 days; and if this policy could have been strictly adhered to, the peaks on transfers would automatically duplicate the peaks on admissions, with a 10-day lag. But no such precision was possible for the following reasons: (1) As a matter of hospital policy, no transfers were made on Saturdays and Sundays, when the doctors were off their wards. So patients whose tenth day fell on the weekend had to be transferred on Friday or Monday; the bulk of these transfers were held over until Monday because other wards did not like to receive patients on Friday. (2) Sometimes patients had to be kept on the admission ward beyond the 10 days until bed space was available on other wards. (3) Sometimes they had to be transferred short of their 10-day stay to make bed space available on the admission ward. Thus, though transfers were made in strict order of rotation, they could not always be made precisely on a 10-day schedule; the patterns on admissions and transfers, therefore, do not exactly coincide.

There were, on the average, three admissions and three trans-

fers per day, and the population of the overlapping groups was a constantly changing one (see Graph 5, Appendix D). In such a situation the cultural patterns and values would be carried on by a process of conscious and unconscious transmissive education, the "older" members being the culture bearers.

Arrivals. Navy personnel in the Oakland-San Francisco area were admitted to the ward directly from dispensaries or after a short stay in station hospitals, and some patients came directly from the fleet in the San Francisco area. Others came from Navy hospitals in the Far East or the Pacific Islands, from units of the Pacific Fleet, and from West Coast Navy hospitals. (See Graphs 6, 7 and 8, Appendix D.)

At first some patients from overseas came via hospital ship; later, however, the hospital ship was decommissioned, and all such patients came via air evacuation flights. We were rarely given advance notice of their arrival, and we had to be always prepared. Though on occasions all 34 beds on the ward were filled, we attempted to keep 10 beds available at all times against an emergency influx of patients.

Most patients were brought to the hospital itself by bus, though a few arrived by other transportation under orders to report to the hospital. They frequently arrived in restraints, and the majority were sedated. (Graph 9, Appendix D.) Often patients were surprised and angry at finding themselves admitted to a locked ward, having been told only that they were being sent "to the hospital." Many patients in disciplinary status arrived under armed Marine guard, here to be evaluated and either transferred to the hospital brig operated by the psychiatric department or to remain on the locked psychiatric ward.

Stay on the Ward. Previous to the establishment of the therapeutic community the operation on the ward had been, as I saw it, primarily an emergency holding and sorting operation. There had been little active organized therapy except as individuals needed or perhaps demanded it. Patients were kept on the ward for various lengths of time, ranging from a day to 3 or 4 weeks, and the lack of any systematic plan of transfer aroused considerable anxiety and jealousy.

At the outset I established a definite period for the stay on

the ward. The patients thus had the assurance that they would leave the receiving ward in systematic rotation and that their period of stay would be relative to that of others. No one would be rewarded or penalized in this regard because of his behavior on the ward. In addition, patients who clearly did not need to be on a locked ward were immediately sent to an open ward. After the therapeutic community had been in operation for 6 months, an open receiving ward operated along similar lines was established in the hospital. Thereafter we sent it an additional number of the less seriously sick patients immediately upon their admission to our ward. (These included patients about whom there was still some slight doubt, and the period of observation on the open receiving ward was used to determine whether they could be transferred to an open ward for their therapy.) Thus during the last 4 months of the program our ward was composed predominantly of very sick patients. But some patients who would have been sent to a closed ward if an initial decision had had to be made improved so dramatically during their 10-day stay that they were able to go to an open treatment ward. This served one of the important functions of our ward.

No patient was transferred to another ward because he was too assaultive or too dangerous to handle in the therapeutic community. One very psychotic patient was transferred after a week to a closed ward for electric shock treatment, and one psychotic officer was transferred after a week to ease a social situation which had developed on the ward. Other than these two cases, transfers were in rotation except for occasional patients who, it was felt, should obviously be transferred to an open ward before the 10-day period was over and at such times as there was a flood of admissions which left us no leeway for possible emergencies.

The fact that the patients stayed on the ward for a short period undoubtedly was an additional influence operating to foster self-control. This was not only because people have a way of holding together rather successfully for known short periods of time, but because the patients were aware—especially the non-psychotic ones—that whether they went to an open or a closed treatment ward depended upon the evaluation of their behavior

during this time.

My exercise of administrative authority in determining which patients were to go to closed wards inevitably caused some anger and resentment. But this was a matter that had to be faced up to. Actually, however, because the decisions were made on the basis of sickness alone and had no punitive quality, there was not a single instance of serious resistance to them.

WARD ROUTINES

The patients on the ward came from a group situation in which obedience, behavior, the fulfillment of orders, the use of chain of command were a part of a somewhat rigid organization. This very orderliness of the life in which they had been casualties was utilized on the ward for their recovery.

The deck of the ward was always swabbed and nearly always immaculate despite the nature of the patient sample—rather, I should say, by courtesy of the patients. Cleanliness, orderliness, and neatness on the ward, as in a ship or as in a favorable childhood environment, are important. If *things* in the small universe of the patient are in order, perhaps emotions and disordered thinking can also find their proper pigeonholes.

The neatness of the ward was possible because of the patients' work details and because of the weekly Field Day, when they turned the ward inside out in preparation for inspection. Working together as a crew with the active participation and guidance of the staff was a form of social work therapy. And the patients who were less seriously sick showed a paternal tolerance for the inadequate efforts made by the sicker ones to help.

Formal sick call began each day as a military ritual which, however, was not an elaborate one.

Formal military inspection itself was a major event each week. The patients clearly took pride in any complimentary comment the inspecting officer would make. (Some of the inspecting officers were quite ill at ease on the "psycho" ward, however, and showed it in various ways. When these officers made inspection it was often easy to see how perceptive patients were and how they sometimes "performed" to fulfill the officer's expectations or indeed to frighten him.)

The orderliness spread into the day's routines. There was, as far as possible, a time for showers, a time for recreation in the courtyard, a quiet hour, regular meals (with adequate and well-prepared food—there were few complaints on this score at any time), regulation of radio and TV by designated corpsmen, a time for bed, a time for rising, a time for occupational therapy, and a regular time for community meetings. There was time also for informal groups, for ping pong, cards, games, and movies three times a week, but there was also monotony and boredom. For the most part there was considerable informal and formal ritual, beginning with reveille and formal sick call and ending with lights out.

Orderliness extended to the use of the bulletin board, which was reserved only for official communications of the staff to the patients; inappropriate use of this message medium (cartoons, comments by patients, et cetera) was considered a violation of orderliness and usually was brought to the community attention. The routine regulations of the ward were conspicuously posted on the board, and fresh copies were put up when the old ones showed signs of wear.¹

Maintenance of orderliness necessitates the use of authority, and I did not hesitate to make statements that clearly implied they were "orders" or "commands" on these matters when the need arose.

INTERVIEWS WITH PATIENTS

Each patient admitted during the working day was seen briefly by me within an hour of his arrival. I felt that this initial meeting was an extremely important one. In it I was always careful to introduce myself by name, to call the patient by name, and to shake his hand firmly and cordially. A weak and indifferent handshake is a poor initial contact and is remembered by the patient; so also is failure to look him squarely in the face. These seemingly minor points of initial contact, together with tone of voice, manner of speaking, and bearing of the officer, are not overlooked by the most psychotic patients—perhaps least of all by them. I paid constant attention to such details as my

1. A copy of the ward regulations posted late in 1955 is given in Appendix A.

wearing polished shoes and a clean, neatly pressed uniform with untarnished braid to convey to them by unspoken communication that, in the matter of dress, I was committing an act of conformity of a sort which I valued and therefore expected them to value.

After the patient had settled in on the ward, I saw him again in a long evaluation interview. Beyond this, any patient who wanted further interviews could arrange for them by signing the "doctor's list" posted on the bulletin board. (This will be discussed in detail in Chapter IV.) Throughout the experiment, one patient selected at random from each consecutive 10-day period was seen in daily 30-minute therapy sessions (see Chapter IV). This was done primarily as therapy for the patient but it served the purpose of providing me with an opportunity to observe more intensively the effects of the social process on the individual, and vice versa. In a sense, however, all patients had a daily interview with me through the community meetings.

COMMUNITY MEETINGS

The aim of the therapeutic community is not peace, but the use of tension through a continuing review of social positions, of behavior, of motivation, so that the ego can assert itself in all. The major therapeutic instrument employed for this purpose is the community meeting, which affords patients regular opportunities of meeting together to discuss with the therapist and with each other methods for overcoming the social chaos they create and the mental chaos within them.



The world is shut out from the hospital in the same way that the world is shut out from a psychoanalytic session. In both cases a therapeutic opportunity is presented to examine the here and now, as a learning situation for use elsewhere, an opportunity for changing, without the usual obligations that the external world imposes. The task is not, therefore, merely getting on with living; the task rather is to take advantage of the opportunity which the group presents to form a relationship which is then intensely examined in the hope of adding something to the ego.

In the therapeutic community at Oakland patients and staff assembled on the ward for 45-minute community meetings six mornings a week, immediately after sick call. Except for purely administrative questions and practical questions of a personal nature, which were usually deferred for individual interviews, it was unmistakably clear to the patients that they were free to communicate to the group any feelings and thoughts that were troubling them. In the early meetings held on the ward, the patients were almost exclusively preoccupied with the question of what disposition would be made of them when they appeared before the "Board," and what compensation they might be able to obtain, or with complaints about their hospitalization. Gradually, however, as the socializing effect of the community meetings carried over from week to week through the overlapping groups on the ward, the range of subjects widened considerably. The meetings also gave increasing evidence of self-control, improved morale, and the sense of being occupied with an important task.

By my comments on the patients' communications I consciously tried to guide the discussion to meaningful ends, but the process of therapy was primarily that which the patients performed upon each other. The impact of opinion upon opinion was sometimes exceedingly sharp and effective. For example, in one community meeting, when an extremely belligerent "psychopath" was delivering a bitter tirade about the enlisted man's lack of freedom to speak out in the Navy and tell the officers what he thinks, another patient turned to him and asked, "Where the hell do you think you are now?"

The following fragment from another community meeting illustrates how the therapeutic process often operated. The patient in this instance was a 17-year-old paranoid schizophrenic named Lind,² who had been transferred to Oakland from another hospital. The note accompanying his transfer told of fears which had made his behavior in this previous hospital so noisy and violent that he had had to be kept in the seclusion room through a large part of his stay there.

During his first few days on our ward Lind sat silent in the community meetings. Then one day he suddenly stood up in the meeting and said, "Do I have to be shot?" I asked him what he meant and he replied, "Someone told me I'm going to be shot."



The other patients, deeply interested, now began questioning him. One asked, "Who told you?" and Lind said, "A sailor; he had three stripes."

Another patient pressed for more specific information. "Exactly who told you? What was his rate? And what were his exact words?" Lind was silent but seemed to be hallucinating. I asked him, "Did you hear a voice?" "Yes," he answered, "but it was the sailor." I inquired further, "Could it have been your imagination?" He replied, "No, it was real." This statement brought visible relief to the other patients; they apparently preferred

2. The names given to patients throughout this book are, of course, fictitious.

to deal with the "reality" rather than the fantasy. Lind continued, "The voice said I am going to be executed."

At this point a sergeant stood up, walked to Lind's side, and said to him in a fatherly tone, "You are not going to be shot. Son, you have a job to do, and we're here to help you. We're a group. There are men on your left and men on your right, and it would be hard to shoot you here. We will help you." (As was frequently observed in the community discussions, the sergeant did not deal with the delusional nature of Lind's communication; instead he emphasized the present reality—the fact that Lind was a member of the group, which would protect him. Indeed he did not even deny that Lind would be shot, only that it was unlikely in these circumstances.)

Another patient, a neurotic, joined the sergeant at Lind's side and said, "The guy who said it should be shot." And a psycho-neurotic with severe phobias solicitously inquired, "How do you feel?" Lind answered, "I am afraid of being shot."

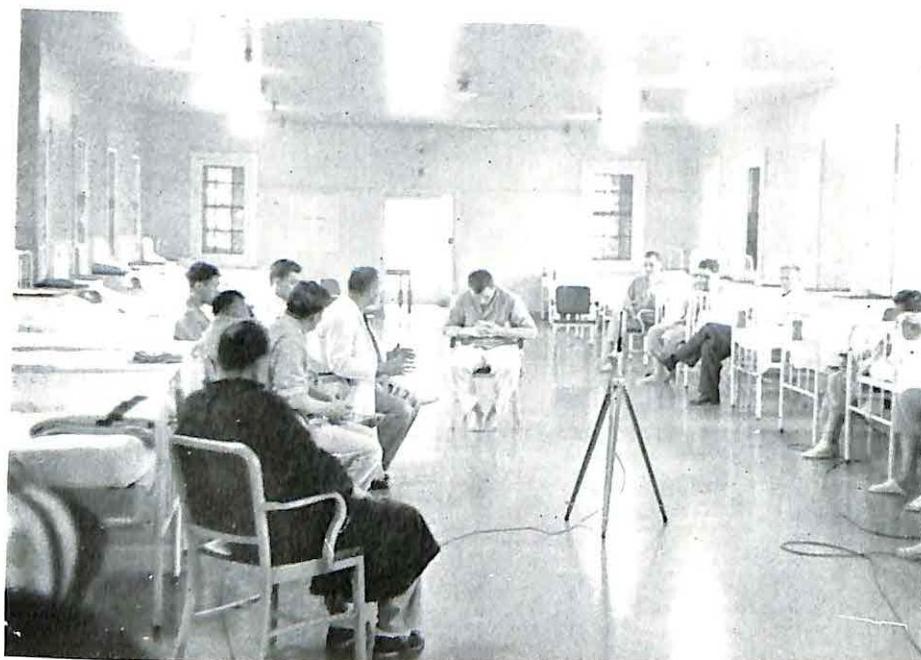
Someone now suggested that perhaps his present fears were related to fears which he had had as a child, and the group



moved on into a discussion of this possibility.

It was observable that, after this meeting, Lind's delusional fear of being executed lost its force. For a few days he still occasionally referred to it, but almost as if he were talking about an abstract idea rather than something which he believed was actually going to happen. And by the end of his stay on the ward, he ceased mentioning it altogether.

The effect of the community meetings also carried over to the other 23 hours of the patients' day in the therapeutic community. Observers who remained on the ward during the entire day were able to report a continuous and rather sophisticated discussion, usually stemming from the morning's community meeting, which helped to relieve the monotony of life on the ward. The patients read, played cards or ping pong, exercised together in the courtyard, organized games, or formed small groups among themselves. Behavior improved discernibly, and acts of violence practically disappeared; incontinence was rare; and even the most psychotic patients were accepted into the community meetings and often functioned exceedingly well, sometimes showing dramatic symptomatic improvement in a matter of days.



The following paragraphs, quoted from an account by Gregory Bateson, the eminent ethnologist, of his visit to the Oakland therapeutic community, sum up the impression which the ward made on an objective and widely informed observer:

"Quiet rooms and restraints were unnecessary in dealing with the random sample of patients which passed through the admission service over a period of many months. My own first impression was that this phenomenon could only be accounted for in terms of 'faith' in human beings. I think, however, that it is not necessary to be mystical about this matter. What there was faith in was, in effect, a rather simple and rather familiar phenomenon, the motivation of men to create a group in which membership is less frightening and not too uncomfortable. This phenomenon had been at work less intensively in the Naval setting from which these patients came. It was an unwritten tradition of the Navy setting, and what was necessary was to admit and foster this phenomenon.

"To the psychiatrist, it might still be surprising that these men, themselves mentally sick, showed such good unconscious judgment in their decisions of when to be impatient and when to be sympathetic. . . . I think, however, that this problem is partially solved when we remember that the daily community meeting is a means by which the psychiatrist is providing a model of the sort of help which the patients will give to each other during the rest of the day." (For Mr. Bateson's full evaluation of the program, from which this excerpt is taken, see Appendix C.)

SOME UNORTHODOX ASPECTS OF THE OAKLAND GROUP THERAPY PLAN

Group therapy as conducted in the Oakland community departed from the customary group therapy technique in several important respects:

(1) It is assumed in most of the published material on the subject that group therapy can operate successfully only with a carefully selected and "optimum" sized group of patients. (The optimum number is usually placed at somewhere between 7 and 12.) To many people, therefore, the most surprising feature

of our community was *the absolute lack of selection of patients* by any criteria or in terms of total number, limited only by the number of beds. We simply functioned with the crew we were given to run the ship, and it worked.

(2) A second point of departure was the fact that *our patient population was a constantly changing one*, rather than the continuous group assumed essential in the conventional concept of group therapy. But we found this situation far from antitherapeutic. In fact, it was beneficial to the community, which was always brought together by facing new challenges, getting new "siblings," and losing others. The changing group, in my opinion, puts the therapeutic community to a new type of test and at the same time offers unique research opportunities.

(3) In a third sense we departed from orthodox group therapy practices in bringing together in the community *mixed diagnostic categories of patients*, ranging from seriously disturbed psychotics to mildly neurotic patients and including a number of "psychopaths." The admixture, we found, was quite beneficial, for not only could members of a diagnostic subgroup help and understand each other, but they often stimulated significant contributions from a different diagnostic subgroup.

The Oakland program, therefore, raises the question whether the traditional group therapy technique of careful selection of group members by rigid criteria is necessary or even desirable. Certainly some selection is inherent in all organized therapy groups, but our observations of the interaction of psychotic, neurotic, and character disorder patients suggests that the very admixture itself, at least on the acute receiving ward, offers powerful therapeutic advantages. Similarly, the mixture of races and statuses was found to be advantageous, as well as the presence of women nurses at a ward meeting with an all male patient population.

Our experience also raises questions as to the so-called "optimum" size of groups and suggests that the traditionally favored number of 7 to 12 patients cannot be made into a generalization. Certainly we found that community meetings with as many as 50 persons present operated quite satisfactorily, and Dr. Maxwell Jones finds that groups of about 100 function well. It is my

conviction that there is no magical "optimum" number. The size of the group which can best function depends upon many variables—the purpose for which it is called into being to function, the nature of its membership, the place where it meets and the manner in which its meeting is conducted, and many other factors. Above all, perhaps, it depends upon the leader—his attitudes, feelings, and sense of confidence and internal security; his memory span and ability to bring diverse things together and see social and personal matters in a new and changing perspective. We found it highly advantageous for the leader to be familiar with each patient's history and to know each patient through personal interview. Whether or not it would be desirable to correlate smaller group therapy sessions in a continuous treatment ward is beyond the scope of this study, and is a subject with which I have no personal experience.

CHAPTER III

THE STAFF

There was a sign on the wall of the Photographic Arts studio at the U. S. Naval Hospital, Oakland, which read: "If you can keep your head in all this confusion—you just don't understand the situation." This exasperating, delightful aphorism perhaps describes the state of mind of the average corpsman or nurse when first assigned to an acutely disturbed psychiatric ward, where so many patients had already "lost their heads." Our mission was to unravel the riddle without loss of humor.

The primary goal of the Oakland therapeutic community program was not to "cure" patients or symptoms, though on occasion discernible symptomatic improvement occurred; the goal was *patient management* through a process of acculturation which would lead the patients to accept their status as psychiatric patients and develop cooperative attitudes that would facilitate their therapy here and on the wards to which they would go after their 10-day stay on the admission ward.

To achieve this goal, the wholehearted collaboration of the ward staff was essential. Their role in the therapeutic community could no longer be the traditional staff role of custodian, turnkey, and sentinel, but the new (yet old and honorable) role of their brother's keeper. Given an ongoing ward with an existing staff, what methods would be most effective in a relatively short time to train the staff members for their new role?

There was no formal preparatory course of training, and no organized lectures were given, though under other circumstances this might have been a valuable adjunct. Training was an on-the-job process conducted through (1) the daily community meetings of patients and staff; (2) daily staff meetings; (3) weekly meetings of the nurses; and (4) weekly meetings of the corpsmen. In addition, the staff knew that they were free to bring

questions and problems to me at any time, and there were numerous informal discussions with them in my office, in the halls, or on the ward.

And from the beginning there was intensive discussion with the staff of the problems which the plan would and did encounter. They were indoctrinated in the *firm expectation* that the patients could and would control themselves in the milieu that we were establishing for them, without the use of the external forms of control to which the staff were accustomed. At first this was probably my expectation only. But the staff gradually came to share it wholeheartedly, especially when they saw it confirmed in action on the ward.

ELIMINATION OF EXTERNAL CONTROLS

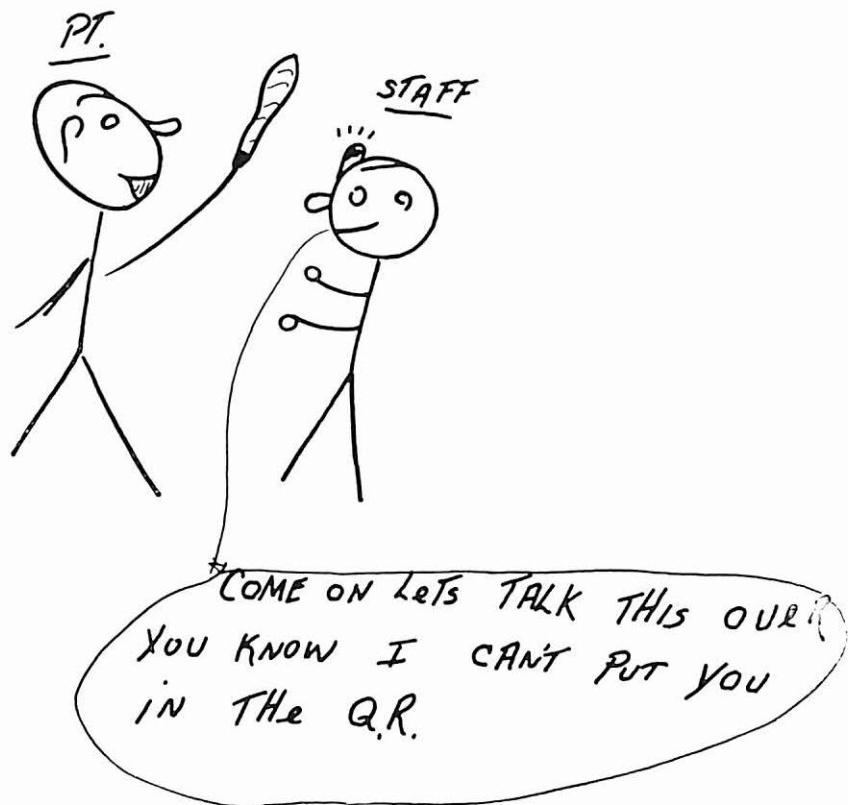
On the first day as a first step toward liberating both patients and staff from the mutual fear and misunderstanding which preclude the type of healthy interaction at which we were aiming, I presented the following procedural instructions to the staff: (1) no form of mechanical restraint is to be used on the ward; (2) the use of the seclusion room is to be abolished; (3) barbiturates are to be administered only under unusual circumstances.

Staff reaction to these departures from familiar mental hospital procedures was at first one of mild consternation and disbelief. In particular, the corpsmen feared that, without the use of the seclusion room, they would lack means of enforcing their requests or orders. A cartoon which one of the corpsmen drew and placed on my desk suggests their anxiety. It shows a patient holding a club over a corpsman's head, and the corpsman helplessly saying, "Come on, let's talk this over. You know I can't put you in the quiet room."

Gradually, however, through their experience on the ward, the corpsmen were largely relieved, at least consciously, of their fears that the patients would do violence. And, with the patients relieved of their fears of harsh treatment, a spirit of mutual cooperativeness developed. In commenting on the difference between the old way and the new, one corpsman said to me, "You should have been here before. It didn't matter how good the corpsmen were; it was how much meat they had on their bones."

He was referring to the physical struggles, which he rather vividly described, that had frequently taken place in putting patients in the seclusion room.

In general, although many belligerent, hostile, and assaultive patients were admitted to the ward during the period of the therapeutic community experiment, the amount of overt disruptive behavior was negligible. I never found it necessary to isolate even one of the 939 patients with whom we dealt, despite the fact that almost every type of acute psychiatric disorder was represented in the group.



This result was achieved largely because the staff, no longer free to use methods of control that brutalize both themselves and their patients, had to find new ways of dealing with patients. They found the new ways more effective and infinitely pleasanter than the old.

A paper published by a corpsman who spent two weeks of his year's duty in the psychiatric service on our ward, interestingly reflects the attitudes and feelings of the corpsmen toward this aspect of their experience in the therapeutic community.¹

He begins by telling that, before being assigned to the psychiatric service, he had often heard it referred to as "the funny farm," "silly hill," "squirrel canyon," "mockingbird hill," and "the squirrel cake," and goes on to say: "As it happened, several of the NP corpsmen, noticing my low rate and sensing my insecurities and misgivings about working with psychiatric patients, as well as my inexperience as a hospital corpsman, made the apprehension all the greater. Stories and accounts of the dangers inherent in working on the psychiatric wards were frequent and the impression given was that the working code of the psychiatric ward was merely a slightly modified 'jungle law,' or 'kill or be killed.' Everyone spoke of the danger and the unpredictability of the emotionally ill patients."

His first day's duty as an NP corpsman on another ward is described as an "endless weird dream." Then "the second day began much like the first. As I was eating breakfast on the ward an angry patient, upset over something unknown to me, threw a tray of chow at me. This *really* frightened me and I thought of all the ways that I could still leave the ward and withdraw from the situation."

He describes the psychiatric service in the year preceding the therapeutic community in these words: "The corpsmen who staff the neuropsychiatric service were assigned to quarters in order that they could be called out 'en masse' for the disturbances on the wards which occurred with regularity. Many times we went to bed at night expecting to hear 'Riot, riot on Ward X. Will all NP corpsmen report to Ward X!' over the public address system. These situations occurred even when we were not on duty, and at times hospital corpsmen from other services were broken out to quell such disturbances. We actually kept dungarees nearby in order to save wear and tear on our white uni-

¹. Rodney Odgers: Attitudes and Social Therapy: Experiences with Advancement in Psychiatric Patient Care. In *Medical Technicians Bulletin, Supplement to U. S. Armed Forces Med. J.*, 7:249-251, 1956.

forms. There was the feeling among many of the corpsmen that they actually felt better after a riot, as they claimed 'this was a way they could get rid of their own hostilities.' " He speaks of the great relief he felt when he was assigned to the brig ward.

After he had been working on the service for a year, the research project herein described was begun, which, he states, "proved to unsettle members of the staff and changed many of the existing treatment procedures. When it was announced that the seclusion room would no longer be used on a closed ward where disturbances were frequent and restraint was freely used, most of the corpsmen, including myself, thought this impossible and snickered to ourselves. One of my buddies was working on the ward, and as he became convinced of these newer ways of dealing with the patients I became curious to see what could be done on such a ward. Inadvertently (sic) I was assigned to this ward, following being on the sick list, and had some feelings about working there. Only two weeks on the ward attending the daily groups and daily staff meetings was enough to more than raise questions in one's mind as to this type of treatment over that being used in the past."

The paper is marked by an extremely sensitive perception of the patients' behavior, observation of spontaneous groups, and evidence of the empathic handling of patients. He concludes: "There is little question that staff members feel more comfortable working in an atmosphere which does not emphasize external controls and restraint. When emphasis is on inner control, each patient in a sense becomes his own control as rapidly as he is able to assume the many aspects of what society expects of him. One of the primary roles of social therapy is to provide an atmosphere whereby the patient can assume his own control and leave the hospital to take up his role as a responsible member of the outside society. . . . Important in promoting such treatment environment is the constant examination of the staff's feeling. . . ."

He notes also that social changes occur in the corpsmen's lives as their working situation changes. "Where frequently the psychiatric corpsmen were seclusive and had little to do with general duty corpsmen, their relations on their off-duty time

are constantly being extended. Where formerly they talked of 'riots,' destruction, and other situations charged with anxiety, they now discuss the merits of group therapy, of relating to patients, and compare the progress of various patients. Occasionally they review with amusement the anxieties involved in former methods of caring for patients and how much less violence and tension is now present on the entire service."

The most important elements in caring for emotionally disturbed patients he sums up as "trust, understanding, kindness and respect for the patient as a human being."

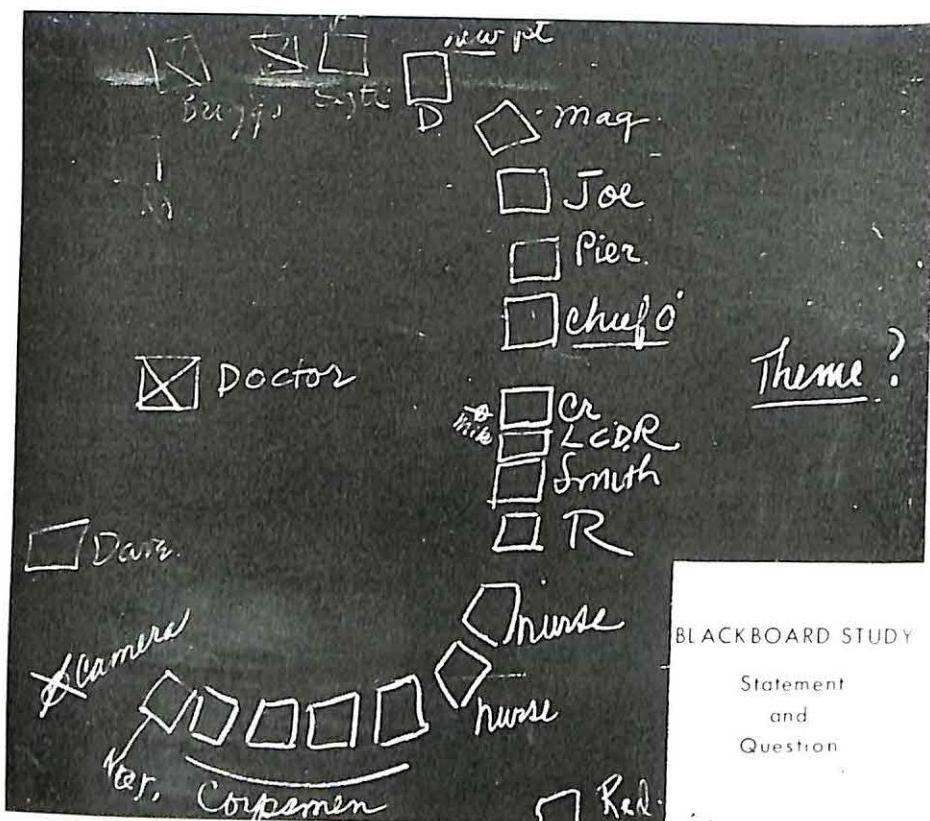
STAFF MEETINGS

Although the movement and relationships of the patients must be a subject of constant study in the therapeutic community, it cannot be assumed that the staff participation is of a stable, static, routine, or well-structured order. The actions of the staff, their inter-relationships, their counter-relations to the patients, and their direct relationships with each other and patients need constant review. They too must see themselves as part of the community, influenced by and influencing it. It is not what can be done to the patient or for the patient, but *with* the patient that is the basic philosophy. This implies a continuing study of staff attitudes and their influence on staff-patient relationships.

The intense study of staff relationships, both by the staff themselves face-to-face and by the leader, is necessary in order to create that indefinable but essential thing—atmosphere—that enables the staff to tolerate all sorts of emotions in the patients. The major device employed for this purpose was the staff meeting. Each day, following the community meeting of patients and staff, a 30-45 minute staff meeting was held in my office, attended by the day crew of corpsmen and nurses, the psychologist and the social worker assigned part-time to our ward, and any professional staff members from other parts of the hospital who wished to come.

We began each meeting by charting on the blackboard the seating positions in the community meeting that had just ended. Early in the experiment it became clear that the position of the chairs in the community meeting was a form of nonverbal com-

munication, whether considered individually or *en masse*. In fact, the staff were soon able to predict with a considerable degree of accuracy how a new patient would behave by the position of his chair in the community meeting. Patients brought their bedside chairs to the center of the ward for the meetings. In group after group the same type of patient chose the same position so frequently that certain positions acquired a specific name in staff terminology. For example, there was a speaker-of-the-house chair, a preacher's chair, a sniper's chair, a guest-of-honor chair, a right-hand-of-God chair, and so on. The tone of the meeting as a whole could also frequently be foretold in the same manner. When the patients were relatively free of anxiety and felt friendly toward each other and the staff, they tended to congregate toward the solarium. When there was considerable tension on the ward, the chairs were likely to be arranged in what the staff called the "fire escape maneuver," toward the door leading from the

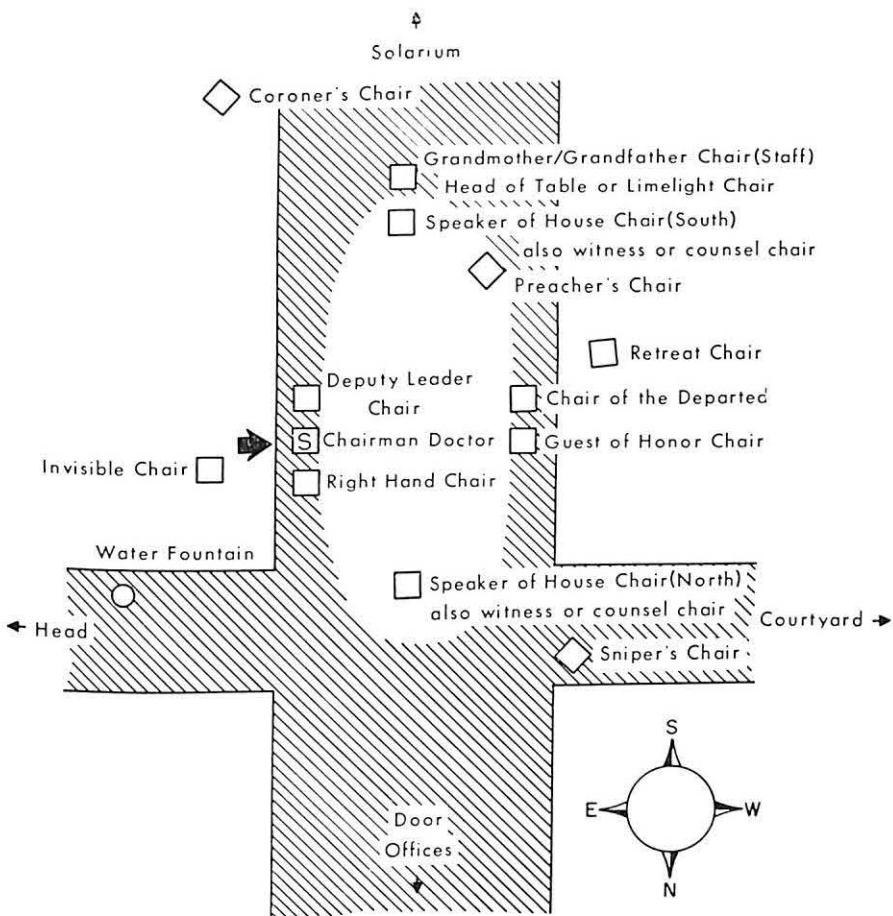


BLACKBOARD STUDY

Statement
and
Question

ward. Chair positions were not analyzed in the community meetings in order to preserve the spontaneity of this phenomenon.

From our practice of diagramming in the staff meeting the seating arrangement in each community meeting, we evolved a number of techniques for representing graphically the positions and movements of the patients as a basis for studying their significance in terms of nonverbal communications.



With the diagram before us, we then analyzed the meeting in detail, step by step, from the first silence and the first communication to the concluding summary and the ward situation at the close of the meeting. This daily forum was an extremely effective

practical device for stimulating the staff's observations of the patients' behavior and developing their understanding of its significance.

It also served as a vital means of management of staff tensions and anxieties, which must be at least partially resolved to permit an effective patient management program. Hostilities and differences of opinion simply could not remain underground for any period of time with such intimate face-to-face daily interaction. To a measure, the staff meeting was a group therapy session though never directed for any length of time at the staff but at the staff-patient interaction.

Moreover, since the staff dispersed throughout the group at the community meetings, they obviously saw and heard many things which I did not. Their observations, therefore, by complementing and supplementing my own, provided a constant source of correction of possible errors in evaluating techniques and procedures.

The meetings served too as a form of transmissive education in which the older staff members of the society indoctrinated the newcomers. (See Gregory Bateson's observations on the staff meetings, Appendix C.)

At the staff meetings there was always speculation as to the probable course of events, but relatively little conscious effort to manipulate the environment to produce them. We all learned much by the process of serendipity—the process of fortunately discovering things that we are not directly seeking.

In particular, then, as a training device, the staff meetings brought order, form, and deeper meaning out of the community meetings and gave the staff insight into the behavior and the communications of the patients. All of this increased the staff's interest in their work and their sense of partnership with me in the total venture.

By the end of the first three months of the therapeutic community program, it was obvious that the staff had largely lost their initial fear of the innovations and had accepted the philosophy of the experiment as their own. They had truly come to regard themselves as fellow-members of the patients in the community and had made this membership part of their conscious

and unconscious habit in their activities and relationships on the ward.

To give the reader an impression of the staff meeting, excerpts from a tape recording of the meeting held on February 2, 1956, are presented.² After we had diagrammed the seating pattern, the meeting carried on as follows:

Excerpt 1

Social worker: Our group is spreading out a bit. It is pulling out. I think some of the staff are sitting down at the other end. This might account for it. I don't know. I have a feeling that it is much better if we sit closer, because I think if the staff sits far away it gives an invitation to the patients to sit far away.

Corpsman: I thought it was just the other way around—that they were not as far apart, that they were sitting closer today than they were earlier in the week. More like a family, patients helping each other.

Doctor: I don't think where we sit makes so very much difference, do you really? Maybe in a marginal group, an unsettled group, it would. Remember the time the staff could not even get in there?

Corpsman: Yes.

Social Worker: The only thing is, I think it is much easier to communicate when they are closer together and I think it does encourage more exchange of thinking.

Excerpt 2

Doctor: The theme was to "help Jones." Don't you think there was an element today of other people talking who had not previously been able to talk or had been intimidated?

Social Worker: That's right.

Corpsman: I noticed Worth right away today, he wanted to do the talking about himself.

Social Worker: He was not able to talk when Jenks was here because he had a fear of him, I feel. Jenks was a fellow probably very much like his Dad. It is the very thing he talked about.

Corpsman: Isn't it so that when someone gives an example of a

2. There were only 16 patients on the ward at this time; 11 were schizophrenics. Three neurotic depressive patients had made suicidal attempts just prior to hospitalization (one quite serious). One patient had a (homosexual) sexual deviant diagnosis, one a severe passive aggressive character disorder with paranoid ideation, and one a passive dependency character disorder. Of the 16 patients, 12 spoke in the community meeting which the staff is here discussing.

problem, they are actually talking about themselves?

Doctor: A good example of this is the patient's question which started this morning's discussion: "Why can't Jones talk?" [Jones was a mute catatonic.] At the beginning of the meeting Allison gave his explanation, "He's got something in his throat and something is wrong with his speech." This is Allison's problem, symbolically referred to.

Banks said, "He is afraid," which is his problem.

Carsten said, "It's something in his early life," which is his problem as he tells us later on.

Davis and Ewarts both said that what Jones needs is his mother. What he needs is affection, which is their problem.

Frick agreed with my interpretation that the trouble with this patient is his imagination. He said Jones has a sickness of the imagination, which is his problem.

Garland objected that none of this made any sense. "You are off your bearing. You are not on the trolley," which is his problem. This guy is psychotic. He is hallucinating. It is not that he is hostile. In his own dream world he is quite right. "I have nothing to do with what is going on."

Corpsman (with enthusiasm): We ought to have a catatonic on the ward all the time.

Doctor: Perhaps that's right. He is sort of a good thing to project on. Sort of like a silent movie filmed into words. You know, this brings up a lot of interesting points. There is the question of projection on the silent member of the group who is obviously in difficulty. This also brings to a head this question of competition in the group which has been going on for weeks.

Excerpt 3

Charge Nurse: Garland came back and said, "We won't sweat this one out."

Doctor: He is lost and he has very great difficulty tolerating another sick patient being the subject of so much attention. Dr. Barrett had the hunch that what happened yesterday was a retaliation on me for Monday's meeting.³

But today you see we can turn to Jones, who has been the most obviously distressing and interesting patient to the group, and they have observed him and identified the people who have been unkind to him. They have been particularly distressed with the

3. See his evaluation of the program in Appendix C.

Chief and Garland, who have been quite sadistic toward this guy, pushing him around, and this subject comes up in the meeting. That is what is good about the meeting. Haskins has to face the group disapproval of this sort of monkey business and it will certainly modify it. It won't stop it.

Now the chief is a long-time problem. The chief, I didn't think would even sit by his rack. I thought he was going to show even more contempt for the group, and I was not going to try to bring him in the group today because it would have failed. I am satisfied that he sat as close as he did and made no overt difficulty. This guy has been in this hospital for a total of 9 months. He is an old hand and is going back to [Blank] ward today. He hates doctors, hates hospitals. He refused yesterday to even come in my office, but this morning I persuaded him to come, though only for a few minutes. He is quite paranoid and quite sick, and I think we have to wait a day or two really.

Charge Nurse: He worked in the galley this morning.

Doctor: I am surprised he worked there.

Charge Nurse: I am surprised he did too. Maybe he was "casing the joint."

Excerpt 4

Charge Nurse: Jones couldn't talk.

Doctor: He wouldn't talk yet; he wasn't going to talk and therefore we were faced with the frustration of the group consciously trying their best to help. Allison moving over there, shaking hands, telling him to relax, telling the other "therapists" to leave him alone. Ewarts, as "therapist," moving over early in the meeting in a very sincere effort to help. Talking to him, saying, "Tell me about your mother and father and your early life." He and the patient were together. He was not talking to the group. He was talking, and then Banks had taken him under his wing at first, sitting next to him, holding his arm, telling him not to be afraid, feeding him. This morning Davis said Jones was not eating enough, not eating well.

Social Worker: (to doctor): What was the question you asked Morton? He said it didn't frighten him but then later he went back and said it did.

Charge Nurse: He thought you said, "What did you fear?" instead of "What did you hear?"

Doctor: Morton's contribution was the most moving part of the meeting obviously, because it touched so many, many points.

Social Worker: It was really too bad this was not brought out the first part of the hour.

Doctor: It could not be. These things are usually brought up at the end of the hour. Remember Morton at the very last minute told how he was hit by the shore patrol with a club.

Corpsman: It seemed to me he sort of felt insecure at home about making decisions. He seemed to be saying, "I don't know what decision to make." He felt very insecure about making decisions.

Doctor: The main point was he could not make any decisions. The little boy could not make decisions and he was not getting any help, no support from people who should come and help, who should have loved him. They didn't love him, they hated him. They didn't give a damn if he fell out of the tree and broke his neck. [This was the first of three stories or screen memories the patient had told.] The little boy up in a tree called for his mother. The mother was busy cooking and she said, "Don't be a child," was not that it?

Social Worker: That's right.

Excerpt 5

Corpsman: What about the story he told about the snake? What do you make of that?

Doctor: I don't remember that.

Charge Nurse: Where he was plowing the field and there were some weeds and the flowers were on the other side of the weeds, between him and the house. He went to get the flowers for his mother and there was a snake there and he again called for his mother.

Corpsman: Every time I think of a snake I think of homosexuality. I don't know why. I think I read a book by Freud. He talked about his father calling him homosexual. About the snake part—always something long. I read about it in Freud's book.

Doctor: Well, we will come to that. What else do you think?

Charge Nurse: Why was he getting flowers for his mother if she would not back him up or anything?

Social Worker: He was reaching out for affection, trying to make the connection.

Doctor: He was desperately hungry, wanting affection, wanting to show affection. He was frustrated. Children who have rejecting mothers never give up the wish to have the mother return affection until they reach the point where it is so obvious that they can't

get affection—that mother does not “love” them. Then either they declare their independence in some way, neurotic or otherwise, or they become psychotic. He became psychotic. He became mentally ill.... not being able to give “flowers” to his mother. No matter how many times he needs his mother, she never comes, but is busy cooking food. The food was for him in a sense but it was not what he wanted. So the flowers never got to her. The snake, I think, is quite significant if you want to get into psychoanalytical things: I say it is a phallic symbol, the symbol of a penis—not homosexual—just the symbol of the male genital organ in his fantasies. Even if it is not a fantasy.

Social Worker: I thought it pretty symbolic of the father.

Doctor: And he is frightened. He didn't tell us that the snake bit the boy or that the boy dies, or that it was a rattlesnake. It was just a big snake that frightens him. He calls to his mother for help and she says, “Don't be a child.”

Social Worker: I wonder if she said, “Don't be a child,” or whether it was, “Don't be a baby.”

Doctor: “Don't be a child.” He is trying to be a grown man like his father and bring flowers to the mother and she said, “Don't be a child.” Don't be what you are. Don't be a child. Don't be afraid of things. She could not overcome her blindness. Now I think about it, there are these hidden aspects. The boy hidden in the tree. The snake hidden in the grass. Even if his mother looked she might not see it, you know. You follow that?

Corpsman: About the tree, yes.

Excerpt 6

Second Nurse: As the meeting broke up and I happened to be taking a chair back, he wanted to take it from me to help me. He said, “You know, I didn't have time enough in the meeting. I never had time enough to talk. I wanted to tell the doctor about the vase. I didn't finish.” He was going to say the color could mean something. For instance, he wanted to say that it might be green and that the little child wanted to have a green car like his father and he said that the color of the car could mean something but he didn't have time to bring it up. He said that what he wanted to do was admire the vase and look at it, and it reminded him of the car. And that is how it got broken instead, because he was admiring it.

Doctor: So the green vase in the possession of his mother, this beautiful, painted, breakable thing that he in some clumsy way

shatters, I don't know if this is right. The only thing is that the mother is the father's, and vice versa.

Social Worker: I wonder if the vase signifies the car in competition to his dad for his mother's affections, the destroying of this car. This is very much on the surface of breaking this vase. Maybe his dad and mother had difficulties over this car together and they excluded him from the family group.

Doctor: In interpretation to the group we won't go off on this. The important things he can handle and use are the fact that in relationship to what is going on in the ward, the coming of mother to protect the child doesn't happen in his fantasy and that the child is afraid of something real but that the mother doesn't pay any attention to it, doesn't recognize it as real. This was very moving, to me anyway. And in the second place, the fantasy about the vase—it wasn't that the child was in danger but that somehow or another he did not understand adult values or what was important. They didn't make sense.

Social Worker: There was an important thing he brought up today about beating.

Doctor: His father beat him with his fists, very sadistic, called him a "son-of-a-bitch," "worthless," "a bastard." I know this from personal interviews. He wouldn't use these words in the group. This is what it is; what really hurt was not being beaten in the face by the fists of the father, but the terrible depreciation with words.

Second Nurse: Something else he was worrying about—about being a man. This morning he came into the office and said he wanted to see a doctor and I said, "Certainly, put your name up there." I asked him what it was about, if it were an emergency, and he said, "It is something I would rather not discuss with you. You might not understand it." I said, "Is it something that is really worrying you?" He said, "Yes." I asked, "Is it something to do with your private parts?" and he said, "Yes. It is my testicles" and I said, "Is something the matter?" He said that he is very worried because he thinks his testicles have grown much more than they should. They are not hurting, but something should be done about it. He wanted to know if this was right or wrong because they were much bigger than last year.

Excerpt 7

Second Nurse: He said he was treated like an outcast.

Corpsman: At this other hospital.

Second Nurse: He said they were all kept in little cells and Burton was there also. Everyone rejected Burton, who had his head on his knees most of the time today. Wonderful work with him. He finally got his head up.

Doctor: An interesting change, without saying hardly a word. Burton told me in my office [reading]: "In my opinion what I like is that people smile here. At the other hospital I was in, nobody ever smiled. On sick call there the nurses jumped on you all the time, no matter what you did. It was the same old routine. My doctor, he never smiled. He argued with me about everything. He is smart. Only the smartest thing he ever did was send me here. They don't have cages here. They have cages there over the lights, they have cages over the windows, they collect the ash trays at night, remove chairs during the day if there is any difficulty and every night they lock the chairs up. I could not have a pencil and I was watched like a hawk. Of course, they watch you here but they don't bother you. The corpsmen there pushed you around, threatened you if you didn't cooperate, and locked the patients up in quiet rooms."

Excerpt 8

Social Worker: Could you relate what he stated about the incident that happened on the ward yesterday? What he told you about this patient being hit?

Doctor: You go ahead and tell it.

Social Worker: Well, when Jones yesterday struck one of the corpsman [he had not been hurt], this patient was out there in the ward and he observed it and he commented on how well the corpsman [corpsman present at this meeting] was able to handle this situation and how comfortable this made him feel. Gave him a feeling of security, which is really the opposite effect of what might be expected. I think many corpsmen feel that when they get struck they lose confidence in the eyes of the patients and that it would be more impressive to the group if they turned around and struck the patient.

Doctor: I think the corpsman handled his feelings of anger—he has not been on the ward very long—very well. What impressed me about this, I walked on the ward earlier in the afternoon and people were shadowboxing about Jones — near him. The corpsman too! I think this was threatening. I don't think you should do that! I think it is a mistake. I think the word "shadowboxing" had meaning to him. The shadows are real. This sort of monkey business to

him means that somebody wants to fight.

This hour highlights many problems of interest to the ward—violence, aggression, seating, self-control, patients acting as observers and as therapists for each other, giving themselves a purpose on the ward, ostensibly to help another but also themselves.

CORPSMEN

The bulk of the work-a-day job fell to the nurses and corpsmen, particularly the latter. It was the corpsmen who had to face the patients through the 24-hour day, for no full-time night nurse was assigned to our ward and two corpsmen had night duty. There were 10 corpsmen billets on the admission ward at the beginning of the therapeutic community program; this number was later reduced to 8 because of a shortage of personnel.

Corpsmen assignments, I regret to say, seemed haphazard, and there was too much mobility in their ward changes. Over the 10-month period we had from 2 to 9 corpsmen changes per month, and a total of 49 corpsmen rotated through the ward during this time, an average of 5.4 corpsmen per billet. At times too we were crucially short of our number; for one week this shortage made it impossible to let the patients out in the courtyard for fresh air and exercise.

But this, like the patient sample, was our given situation, and the frequent turnover did not disastrously affect our work in the therapeutic community. Occasionally, in fact, the result was a stimulating one, for new and inquisitive corpsmen sometimes brought fresh observations and constructive criticism to the ward operation.

Corpsmen in a Naval hospital can function as variously as any crew of any ship. Under adverse conditions, when they are rebellious or their morale is low, they can consciously or unconsciously sabotage the best-intentioned program by the effect that their attitude has on the patients' behavior and illnesses. Under other conditions they can heave to with an amazing *esprit de corps* exceeding all expectations. The average corpsman in the Navy is a person of good qualities and is often highly motivated and interested in his work. The corpsmen on our ward, though

not selected by us, gave a great deal of themselves to their jobs. Most of them had had no previous special training and some were assigned to our ward as their first job in the Navy. A few, however, had graduated from the Neuropsychiatric Technician's School at Oakland.

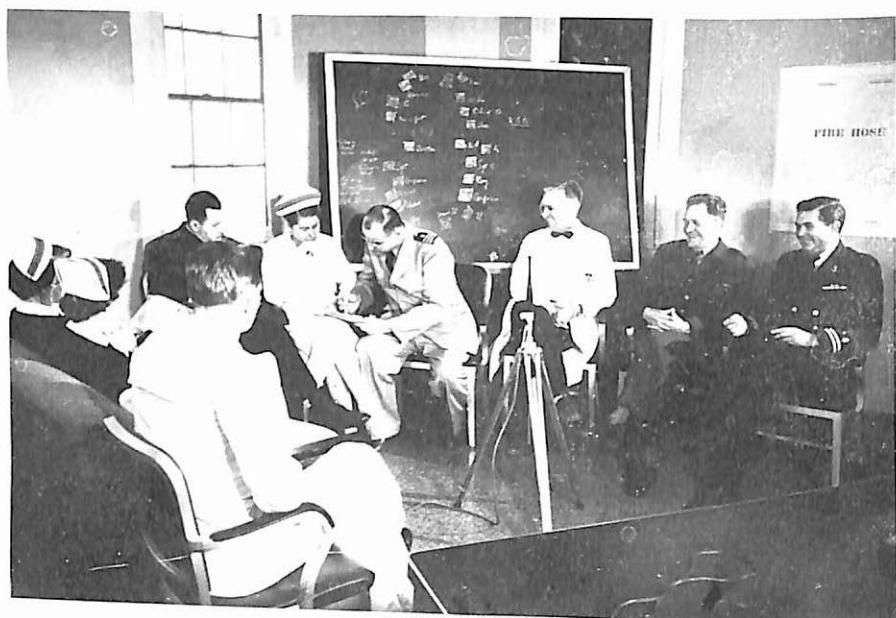
The corpsmen were under the direct control of the charge nurse on the ward. Some performed administrative tasks such as carrying out formal admission procedures, typing records, preparing patients for admission and examinations, keeping records,



dispensing medications, escorting all patients who left the ward to go to X-ray, electroencephalographic, and other laboratories and to psychology for testing. They also supervised ward routines concerned with order and cleanliness. They served chow and supervised the galley. They helped organize Field Day once a week, when the patients cleaned the ward thoroughly and assisted in ward preparation for weekly formal inspection by high ranking officers who inspected all wards in the hospital much as on a ship or at any shore installation. Patients and staff worked

together at all these tasks, usually with a high degree of harmony. Patients swabbed the deck, cleaned the head, helped in and cleaned the galley, assisted in moving chow carts, and cleaned the dishes.

The corpsmen ate with the patients after serving them. All meals were eaten on the ward at tables otherwise used for recreational and other purposes. Corpsmen fed some patients and took over many traditional nursing functions. On a few occasions I heard that they sat by a patient's bed throughout the better part



of a night. In the community meetings, when corpsmen were criticized or verbally attacked by new or grossly disturbed patients, the other patients invariably rallied to their defense, always citing examples of kindness and helpfulness which they had actually seen or heard to support their position. At no time was there a wide breach between the corpsmen and the patient group.

Meetings with Corpsmen. I met with the corpsmen for 30 to 45 minutes once a week, usually in the afternoon at a time when both the morning and afternoon crew could be present. If they had no particular problem, I presented a case for discussion. Often, when it came to their attention that a patient had been

placed in the quiet room on the ward to which he had been transferred, they expressed their relief at not having to "throw patients in the quiet room." The meetings clearly increased their confidence and their sense of personal participation in the care of the patients. They gave the corpsmen a chance to speak more freely than in the staff meetings, where some felt inhibited by the presence of the nurses and other officers.

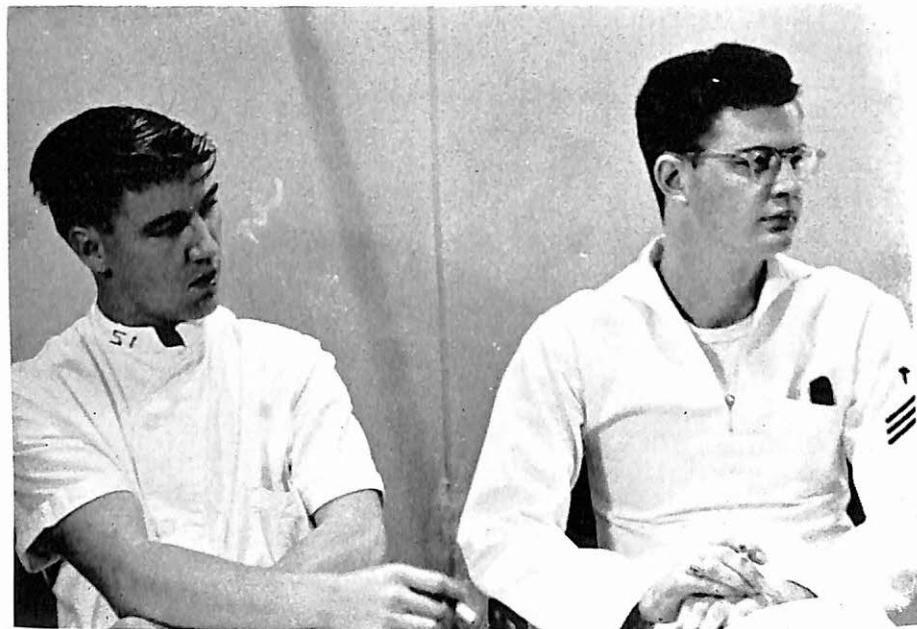
It was not infrequent after the discussion of a case for them to express disappointment that our patients could not be kept on



the admission ward for prolonged treatment so that they could then experience a fuller satisfaction in seeing the continued improvement of individual patients. While this was one of the frustrations of a constant turnover of patients, the pace was such that the repetitive challenge in the fast tempo of the ward gave little time for reflection and regrets. Some of the wish to treat patients longer was probably also a wish to escape the pressures created by the continual influx of new patients. In the beginning of the experiment, each new patient constituted an unpredictable threat and a possible "test case" which they feared would shatter their confidence in themselves and discredit the philos-

ophy of the ward. After several months the overwhelming number of patients whom they handled satisfactorily gave them confidence and eager curiosity to meet new patients. I think they were also curious to see how I would deal with varying situations and patients.

This curiosity was a constant phenomenon which might have accounted for much of their silence in the community meetings as they became observers, though some explained their silence as a fear of saying the wrong thing or waiting for me to put



some of their thoughts in words more clearly. But there was also a hesitation because they knew that anything they said in a community meeting might be discussed in the staff meeting. Had our corpsmen remained on the ward for longer periods, these inhibitions might have been reduced.

Corpsmen anxieties in their early meetings took such forms as, "You may be able to get away without putting this patient in the quiet room but what I'd like to know is what will we do when we get a patient like Sgt. Milligan on our ward?" I answered, "The same." Another similar question was, "But what

will we do when a patient really becomes violent?" My answer was, "They won't." At first they were skeptical. Another source of uneasiness was the lack of explicit instructions as to what to do in precise situations and of routine orders to cover emergencies.

Not infrequently a corpsman would bring into these meetings personal problems, viz., "My mother-in-law is angry at me because we let our baby suck its thumb, and I wonder if that is bad?" In the discussion he pointed out that his mother had talked to him about thumb-sucking and he half shares his mother-in-law's concern. Rather than deal exclusively with his personal problem in the corpsmen group, such problems were ultimately reflected upon as to their relevance to problems on the ward; in this instance about a regressed schizophrenic with a "feeding" problem. The theme of this corpsmen's meeting turned out to be: How can we carry on without being too greatly influenced or disturbed by feelings aroused by what significant people say? How can we face criticism when reason tells us we are right? How does one maintain independence and self-respect?

The Night Crew. The same two corpsmen had night duty throughout the period of study. They were therefore unable to attend the meetings on the ward. At their suggestion they and I exchanged daily notes so they could be kept informed on the community meetings and given pertinent details which would affect patient care. These communications served in some measure to bring the night crew into the staff meetings, where their notes were usually read. I also met informally with them late at night for about a half hour every 8 days when I had duty as Officer of the Day. In addition the nurse and the psychologist were in frequent contact with them when they had night duty. While they were somewhat isolated, they seemed to have perhaps the strongest sense of identification with the group and the experiment of all the corpsmen, perhaps because the entire patient care rested on their shoulders alone for long lonely periods of time, a responsibility they carried out exceedingly well. Many times at night when I sat on the ward with them I was astonished at the degree of patience they showed in the face of disturbed patient behavior. Indeed they prided themselves on their patience and its rewards, that of seeing improvements result and of

having my explicit and implicit faith and support and reassurance. Unlike the day corpsmen with their frequent changes in peer group, they stood together constant and united.

Some of the notes left by the night crew and myself are shown in Appendix B.

NURSES

In addition to the charge nurse there were two morning nurses and one afternoon nurse on 8-hour shifts on the admission ward. A night nurse was also assigned to the service to cover many wards, including ours. During the 10-month period the full-time billets on the ward were filled by 11 different nurses, 5 of whom began their service at Oakland on our ward. One nurse requested to be transferred to our ward and none left us at her own request.

Every morning when I first reported to duty I would meet with the charge nurse in my office for 5 or 10 minutes. Here we would plan patient transfers, and she would bring me up to the minute on events on the ward.⁴ She was in many ways an exceptional person—sensitive, dedicated to patient care, skeptical but reasonable, with a high degree of good intuitive powers. She was an excellent observer of patient behavior and quick to pick up clues. Her loyalty and competence were major elements in the success of the experiment.

The staff was considerably influenced by the fact that the supervising nurse of the psychiatric service attended all community and staff meetings. She was in constant touch with all the other psychiatric ward staffs and made frequent visits to the other

4. It is interesting that the information given me at the start of the day had several significant areas of withholding: (1) I was rarely told about eating problems until I had observed them. This might have been related to the clear nursing and "mothering" responsibilities involved in these problems. (2) On the occasions when Officers of the Day had put our patients in the quiet room at night, both the nurse and the corpsmen at first withheld this information from me, perhaps out of reluctance to cause me annoyance or anger. (3) The nurse sometimes also did not tell me of special types of ward crises which she thought would become evident in the morning's community meeting. This was done partly out of curiosity as to how I would meet the unexpected crisis. This at first annoyed me, but later I came to appreciate the fact that it did enable me to face the ward meeting without being prejudiced or influenced by tip-off clues.

wards where she observed and talked to patients whom she had first seen on the admission ward. In our daily staff meetings she would report on the current state of any of our previous patients when there was progress, deterioration, or any pertinent change. This served as a valuable type of follow-up.

Meetings with Nurses. Once a week in my office I met for an hour with the nurses from all the psychiatric wards, including our own. These meetings were used as educational seminars dealing primarily with staff nursing problems and tensions. There was no planned course of lectures. The content of the meetings took its direction from the questions and problems which the nurses brought up. Sometimes I would present a case history from the point of view of a particular problem in patient management. At other times I played recordings of parent-child conflicts to stimulate thought on the problems they dealt with or gave a talk on a subject they requested. Many times they brought up personal problems and feelings, which were dealt with primarily insofar as they related to the socio-environmental forces in the hospital. This is not to say that personal psychotherapeutic aspects were not touched upon, but these meetings were no more primarily for psychotherapy of the members than were the community meetings.

The nurses were quite a candid and sophisticated group. The great majority of them seemed to be dedicated to a career in nursing and eager for understanding of ways to help patients. Their interest seemed to increase and their anxieties diminished as a result of the discussions.

Their traditional training led them to seek precise answers and directions and to want things to be black or white, definite and precise and authoritative. For example, one meeting began with a nurse asking, "How do we handle this patient—permissively or firmly?"

A fairly typical nurses' meeting dealt with the question, "Can you treat all people the same? If you spend a good deal of time, for example, tube-feeding a very sick patient, does this special care create special problems?" The consensus was that it is probably reassuring to the other patients. Then someone asked, "What do you say when a patient says, 'I want to tell you something

but you must promise not to tell the doctor?" Privileged communications were carefully analyzed, and we discussed the dangers inherent in nurses' developing certain "contractual" relationships with selected individuals and the question of how far a nurse should go in commenting upon and interpreting intimate private communications from patients. On our ward the nurses, so far as I knew, never made deep interpretations to patients, partly because of explicit instructions and partly because of their identification with me, for I rarely made deep interpretations in meetings. I always avoided the exquisite type of insight interpretation which sometimes intimidates patients or overwhelms and confuses them with jargon. Nurses were urged to reflect upon meaningful comments by patients, if possible to express their own feeling response, and to talk simply, patiently, and honestly with patients, always directing their psychotherapy back to the community meeting or to the doctor.

The psychiatric nurses were deeply disturbed by the insensitivity of nurses in other parts of the hospital toward the patients in the psychiatric wards. For example, one of them said that, while taking a group of patients to another part of the hospital, she had been quite audibly addressed by a nurse who said, "Are you taking your nuts for a stroll?" She felt a terrible sense of humiliation on behalf of the patients.

The chief nurse for the entire hospital came to some of our meetings, and on a number of occasions I lectured to all the nurses in the hospital. But the acceptance of our concepts had a long way to go in overcoming deep fears and prejudices ingrained by traditional training and experience.

PSYCHOLOGIST

The psychologist assigned to our ward functioned largely in a research capacity. He attended all meetings, conducted some when I was away, and spent long times on the ward observing and talking with patients. While the psychologic testing was done by other psychologists not assigned to the ward, when special interest was centered on any patient he would perform more extensive tests himself.

After the staff meetings he would remain on the ward peri-

odically to observe the spontaneous patient groups and discussions which followed the meetings. During the time of the filming of meetings, simultaneous tape recordings were made which he played back for the patients immediately after the meetings. All of these observations he would bring to the staff meetings, which began on such occasions before he returned from the ward. In the afternoons he would hold meetings with corpsmen and with patients on other wards and was active in teaching in the NP Technicians Corps School. In a measure he served as a culture carrier to the rest of the wards and had a strong influence, particularly with the corpsmen.

Like the rest of the staff he served as a valuable source of feed-back and was particularly helpful to me in innumerable discussions.

SOCIAL WORKER

The social worker on our ward had at one time been a line officer in the Navy but was now a civilian. In addition to his responsibility on the admission ward, he was head of the department of social work for the entire psychiatric service. A person of considerable experience, he had previously conducted group meetings on the admission ward for the discussion of administrative problems of NP patients, the various types of disposition, and legal and social service matters. This had led to a certain amount of patient preoccupation with these matters, a fact he was quick to perceive. An indefatigable worker who attended all meetings, he brought to us the valuable point of view of the social worker and each day acquainted us with information (usually from relatives and other sources) relevant to our discussion. In his interviews he recorded patients' reactions to the therapeutic community as another type of feedback information.

ROLE OF THE DOCTOR

In mental hospital management there has been a growing tendency in recent years to separate the roles of administrator and psychotherapist. The major advantage attributed to this plan is that, by displacing on the administrative psychiatrist the

hostility aroused by the restraints and restrictions of hospitalization, it enables the psychotherapist to deal more freely and effectively with the "deeper" emotional and mental aspects of the patient's illness. The dichotomy, of course, is not complete—the administrative psychiatrist inevitably enters into psychotherapy, and the psychotherapists' recommendations and suggestions inevitably affect administrative decisions about the patients. In fact, the plan apparently works best when there is close communication and cooperation between the psychiatrists in the two roles. In a few well-staffed hospitals this program seems quite successful.

No doubt the therapist often feels more comfortable with the patient when he can shift the administrative responsibility to other shoulders and assume the purely "aseptic" therapeutic role, free from entanglements with some of the patient's everyday problems. But in the military organization, such a dichotomy would be totally unrealistic. The patients would be extremely skeptical of the assumption that an "officer" psychiatrist would have no influence on administrative decisions concerning them. To abdicate his administrative role, the psychiatrist in the service would have to remove his officer's insignia. On the ward at Oakland, therefore, I was both administrator and therapist.

Since the admission ward was an operative unit of the hospital, and not primarily a research project, my administrative responsibilities included the routine duties of the medical officer on a busy receiving ward—conducting admission and evaluation interviews, writing admission notes, talking to relatives, answering innumerable telephone inquiries, and in general assuming responsibility for the running of the ward. Physical examinations were done by the Officer of the Day, the intern, and sometimes by me.

In the community meetings I consciously played the role of therapist, attempting by my interpretations of the patients' communications and my summaries of the discussion to direct the patients to a meaningful examination of their emotional and mental problems. In the individual interviews I was either the administrative officer or the therapist or both, depending upon the nature of the problem which the patient brought to me.

In relation to the staff, I felt that my status role called for a degree of real friendliness and an openness on matters pertaining to the patients that should be communicated to the staff to make their work more enlightened and effective and more interesting to them. But I felt also that the staff were independent and equal members with me of the community, and not dependent extrusions of myself or my personal possessions. (As Kalinowski comments, "You can't have your slave and eat him too.")

The staff all worked toward the same common goal—the care and management of the patients. Any differences, problems, and tensions within the staff group were relatively short-lived. As the only medical officer on the ward, I was the leader to whom they must eventually turn or reconcile their feelings about. Had there been two doctors, or had there been an administrator and a psychotherapist on the ward, the possibility of playing one against the other would have magnified potential disruptions.

The administrative role, I found, in no serious way interfered with the therapeutic role; in fact, with our particular patient population, it could often be utilized very advantageously for therapeutic purposes. For example, since most of our patients were not on the ward voluntarily, their primary interest was often in administrative questions—"When do I leave this ward?" "What ward will I go to?" "Will I go back to duty?" To have shrugged such questions off by saying, "You must talk that over with the administrative officer," or "That is nothing I have anything to do with," would have led the patients to think, "So what? Then what have the meetings got to do with me?" The fact that, almost without exception, the patients all attended the community meetings willingly probably attests to the effectiveness of integrating the administrative and psychotherapeutic functions.

I am not attempting to establish any blanket rule on this subject for mental hospitals in general. I am merely reporting my observation that the integration of administrative and therapeutic functions is possible and does not necessarily interfere with psychotherapy. In our particular situation, in fact, an artificial separation of the two functions I believe would have seriously weakened the therapist's position.

Utilization of the Officer Role in the Therapeutic Situation.

A psychiatrist taken from civilian practice of individual therapy and placed in charge of a military psychiatric ward may conclude that he can no longer do "psychotherapy" or may be led to choose a patient here and there for individual therapy and disregard the majority of the patients. However, it seems to me that he can function efficiently as a therapist for his entire patient population: (1) if his own conscious and unconscious feelings about authority and about his current authority status are "healthy" and (2) if his own "personality" is adequate in terms of his sense of security and his lack of fear of the patients.

The military situation, in fact, presents a unique opportunity to study the therapy-authority problem, for the psychiatrist in military life cannot relinquish either his therapeutic or his administrative responsibilities except by rationalization or by administrative maneuvers to disguise or circumvent the reality of his role. He stands also in a unique position so far as transference is concerned, since he wears the uniform of authority, and specifically of that authority with which many of his patients have recently been in open conflict. But in people the feelings toward authority figures—parent surrogates—are mixed. His own feelings about his own authority are more important than the clothes he wears. These feelings will often determine whether he arouses negative or positive feelings in his patients and whether he arouses them for therapeutic or antitherapeutic uses. I doubt that he ever stands neutral or can pose in a legitimately neutral position as the private practitioner or the analyst can.

Beginning, therefore, with this premise, the question is: How can he use this dual role for therapeutic purposes? His manner and attitude toward patients and staff can obscure but never obliterate the hierarchical traditions. Thus the medical officer is—or should be—like the line officer, a leader. His men (i.e., the patients) quite rightly expect leadership qualities in him. Wisdom lies then in a full acceptance of the authority inherent in the officer role and the exercise of it in the therapeutic situation to achieve the healthy repressions essential to the orderly functioning of his "command."

In the Oakland therapeutic community I found that my identi-

fication with the Navy in a role clearly defined by military custom—my authority, not only as a doctor, but as an officer—gave force to my expectation that others would remain in their roles, however sick they were; that this was their task. They were required by these roles to respect the corpsmen and nurses and to behave in the full knowledge that they were within the Navy culture. Thus the Navy culture itself was utilized to strengthen the structure of the unit. Occasions were provided for discussing the difficulties the men had in fulfilling their roles and for investigating how far their own inner difficulties gave rise to difficulties in these roles.

But no retreat from real life into irresponsible, infantile regressions was encouraged or sanctioned. The pain of having to remain in contact with reality, of having to fulfill a role in it, together with the anxieties, depressions, and paranoid feelings it gives rise to, is the essence of the illness. To help the patient retreat from social reality is no part of psychiatry's task. Rather its task is to analyze what it is in the patient that gives rise to pain in the context of his encounter with reality. This is not to say that reality has caused the illness, but rather that it has highlighted anxieties which are typical for the patient and which are now in his internal world.

On theoretical grounds alone we do not expect that removing the pressures of external reality on the patient is likely to be of great benefit to him. To collude with his regressive needs may be unwise, for it is the regression and the causes of it that must be treated. To put it another way, the patient must be given permission to be ill, to feel his pain, to have his depression or paranoia or whatnot, but the psychiatrist should not help him evade the fact that reality exists and that its demands are to some extent inexorable. The psychiatrist must be a sort of commanding officer who, in the middle of a retreat, takes a stand against a panic. His job is neither to shoot the deserters nor to lead the retreat, but to remain a representative of the social tasks upon which his men, for better or worse, must engage. Neither punitive nor lax, the psychiatrist must be on the side of the ego, that part of the patient's makeup which has to mediate with reality.

Thus freedom in the therapeutic community was never synonymous with laissez faire. There were definite limits on behavior. Freedom to be ill or frightened is one thing; freedom to run away and retreat from society or the Navy is another. Freedom to be angry is one thing; freedom to strike is another. The essence of the analytic situation is that the patient is free to feel and free to put these feelings into words. He is not, however, free to act except within the confines of the formal analytic role expected of him. Freedom is thus a relative concept, just as democracy is a relative concept, just as permissiveness is. Any attempt to be absolute on these matters is as arbitrary as full discipline and repression.

Some Observations on the Group Therapy Technique. The fact that any person who gets patients together in a group meeting is *ipso facto* said to be conducting group therapy makes for considerable confusion as to what group therapy is and what it aims to accomplish. The technique employed in group therapy is a highly precise and complicated one, different from that employed in individual therapy and, I believe, more difficult.⁵ Unless this technique is employed, the term group therapy cannot be accurately applied to group meetings.

It is a technique of creating an atmosphere in which the patients will take over the meeting as their own and, with a minimum of guidance from the therapist, will freely discuss their problems with each other and with him. Ideally, no patient will remain withdrawn from the group; all will sooner or later become involved in the discussion. To achieve this result, the leader must have the skill to set the patients at ease and to relieve emotional tensions that block communication. Thus he must be quick to catch clues to resistances, and apt at interpretations that will lead patients to a deeper examination and revelation of themselves and the feelings and thoughts that are troubling them. His manner must be informal and easy so as to encourage the patients to speak freely, and his interpretations of their communications must be simple and direct.

5. Foulkes says of it, "Within a different framework and with more ambitious aims, it is an instrument so delicate and yet so powerful that skilled handling demands more from the therapist than the most difficult individual analysis." From *Principles and Practice of Group Therapy at Northfield Hospital*.

The function of the community meeting is such an important one that it cannot be relegated to subordinates except for short periods but must be assumed by the leader of the therapeutic community himself.

To conduct group therapy successfully, the leader should be a well-trained psychiatrist of considerable experience. A deep understanding of psychoanalysis is also highly advantageous, and perhaps even essential, for although the meetings are conducted on the ego level, constant awareness of the unconscious processes is extremely important in interpreting the patients' communications and directing them toward therapeutic ends. In addition, the leader's own anxieties should be well under control, particularly those relating to implied or expressed feelings of hostility. Given these prerequisite qualifications, the psychiatrist who is willing to learn "on the job" will master the technique through experience with the group itself.

CHAPTER IV

REQUESTED INTERVIEWS AND SPECIAL TREATMENT CASES

INDIVIDUAL INTERVIEWS

A simple routine procedure was established in the therapeutic community by which patients could arrange for individual interviews. We posted on the bulletin board a sheet of paper headed as follows: "Any patient who wishes to see the doctor, please sign below. You will be taken in order as time permits." This openly posted "doctor's list" was our way of informing the patients that in the therapeutic community there was easy access to the doctor for help on their personal problems. It also precluded any risk of my making a verbal promise to see a patient and then forgetting about it. It was a device tailored to this specific situation.

With rare exceptions patients who signed the list were seen within 48 hours. Time was set aside for this purpose toward the end of each day. I would walk onto the ward, call the first name on the list loudly, and with a visible flourish check it off. The list was gone through in this manner, each name being checked off as it was called so that everyone could see what progress had been made and where he stood at the moment in relation to others. During the 10 months of the experiment 28 separate lists were posted and filled and then taken down and kept for later study.¹

1. The patients usually wrote or printed their names neatly and followed them by their rank and the date. On rare occasions they would indicate that the request was urgent. One patient with an aggressive character disorder, for example, wrote after his name, "Very Urgent," and a schizophrenic added a large printed message. "Call Texas if possible, very urgent, and to have someone visit me if possible." Another schizophrenic wrote, "Out of this civilian b.s. aid first on the doublee, as it is very important." This message was signed, "Private Retired." Urgency in au-

The mere fact that the patients could see the doctor by conforming with so simple a ward procedure was in itself a type of reassurance that probably tended to reduce the number of requests for interviews. And the fact that the list was openly posted undoubtedly had some restraining influence on requests of a frivolous sort from the peer group. The patients scrutinized the list carefully and brought certain pressures to bear (as I learned from therapy case interviews) on those who made such requests repeatedly.

The list stood, in a sense, as a bond and a contract between the doctor and the patient. It was visible evidence to the patients of the doctor's good faith. But it was also visible evidence of the load of work falling on his shoulders, and realization of this fact often led the patients to show a remarkable degree of consideration. When the list was long, the interviews often became short because the patients themselves tried to say what they had to say quickly so as not to make a great demand on my time. Often, when I interviewed patients beyond working hours, they would voluntarily say that they didn't like to keep me so late and that their question could wait until the next day.

On my part, I regarded the fulfillment of the requests as a contractual obligation that could not be scamped. One night, for example, I was several miles on my way toward home when I suddenly realized that a patient whose name had been on the list since the previous day had been skipped over, as he was off the ward having an X-ray at the time I came to his name. He was a neurotic patient who, I knew from previous interviews, felt a considerable amount of anxiety about being on a locked ward and some covert hostility toward the staff for their necessary role in his hospitalization. I returned to the ward immediately and called him to my office. He did not know, of course, that I had left the hospital and returned, but it was clear that he

other case was indicated by the heavily printed word "Paramount" after the patient's name. Occasionally, also, a name signed on the list was later crossed out. But with these few exceptions, the list was kept neat and orderly.

One morning when I went to replace the filled list which had been removed the night before, I found one already on the board, headed "To See Doctor." I asked who had put it up and a patient said proudly, "I did." His name had already been signed, the first on the list.

believed I was not going to see him and that he was angry about it. His relief was so great that the interview turned entirely to that, instead of to the reason for which he had requested the interview—indeed, he said that he had forgotten what it was. The interview was only a short one, less than 5 minutes, but when he returned to the ward he assured me that he now felt all right; whatever had been the trouble was no longer bothering him. Following this, his anxiety decreased; he continued to say that he felt "better"; he did not again request an interview. I did not, of course, enjoy having to drive back, but if the promise implicit in the list had not been fulfilled, his anxiety and hostility would probably have been intensified by my failure to keep faith with him in this matter; moreover, in the long run it would have been more trouble and work for me.

On another occasion when I had inadvertently overlooked a patient whose name was on the list, this patient's behavior in the next day's meeting was entirely unlike his previous behavior. In an interview with me after the meeting, his feeling of rejection and his resentment over this "discrimination" against him were very apparent. He had interpreted my oversight as confirmation of his own sense of worthlessness, and his anxiety had been so greatly increased that my explanation and apology only partly allayed it.

In our times, when ataractic drugs are sometimes given at a drop of the hat for symptoms of anxiety, these two cases may have implications on the genesis of anxiety and on its amelioration by social means rather than by drugs. The justification often given for using medication in such instances is that there isn't time to sit and talk to the patients. But my experience was that the amount of time spent is not so important as the manner in which it is spent.² On occasion the doctor may have to tell the patient that he has only a very few minutes, but he should never act rushed or impatient at giving those few minutes. Despite any given limitations on his time, he must sit relaxed and waiting,

2. Elton Mayo suggests a formula that can be taken as a useful guide in interviewing a patient: "Listen without interrupting and watch for what he says, for what he omits, for what he takes for granted, for what he cannot say without help; and remember that what he says may be the opposite of what he wants but does not dare be recognized as saying that he wants."

practicing what Russell Dicks has called "the ministry of listening" in a manner that will bring to the patient a genuine sense of interest in his problem. It is probably impossible to disguise or conceal the unconscious communications of the doctor who grudgingly gives his time or who feels resentful toward his patients for their demands upon him. The nonverbal communication to the patient must be an assurance that whatever can be done on his behalf is being done and that we will not raise more dust than we can settle.

In private interviews patients would often talk to me freely, and I often regarded such communications as confidentially as if I were in private practice. Yet no explicit "pact" was ever entered into with any patient who might ask to tell me something "off the record." But if I felt that it was not appropriate to make such information a part of the record, I did not.³ Nor did I later tell the group in the community meeting anything told me in such an interview, though I commonly urged the patient himself to do so.

*Statistical Analysis of Requests.*⁴ The doctor's lists for the 8-month period from August 1, 1955, to April 1, 1956, show that 383 of the 810 patients admitted to the ward during this period (47.3 percent) requested interviews. The number of requests totaled 766. In relation to admissions, the proportion of patients requesting interviews was consistent month by month. (See Table II.)

3. Medical records, despite their supposed confidential sanctity, are not so restricted as one would like to think. Many of them will follow patients back to their duty stations and will be seen there by hospital corpsmen. When I first reported to duty one of the psychiatrists, knowing of past unfortunate situations in this regard, advised me, "Never write anything on the patient's health record which you wouldn't want read over the PA system of a ship." (The health record, unlike the hospital record, accompanies the patient to every station that he goes to in the Navy.)

On these matters there are limits to which one can trust staff. Their training and experience vary, and some of them will show scopophilic interests which should not be fed. Likewise there are wide variabilities in the ability and "maturity" of psychiatrists, psychologists, and social workers, and there are limits to which highly confidential information about patients should be entrusted to them. But, of course, the question goes deeper than merely a matter of trust— it is a matter of the fundamental philosophy of a physician and the ethic traditions of his profession.

4. Graphs 10, 11, 12 (Appendix D) relate to this section.

TABLE II

REQUESTS FOR INTERVIEWS IN RELATION TO ADMISSIONS BY MONTH,
AUGUST 1955—MARCH 1956

Month	<i>Admissions</i>	<i>Requests for Interviews</i>	
	<i>Number</i>	<i>Number of Patients Making Requests¹</i>	<i>Number of Interviews Requested</i>
August	91	48	91
September	90	44	69
October	86	40	96
November	100	57	103
December	102	41	87
January	127	52	101
February	86	35	76
March	128	66	143
Total	810	383 ²	766 ³

1. Patients are credited to the month according to the last day they were on the ward.
2. 47.3 percent of patients admitted.
3. An average of 2 requests each for the 383 patients requesting interviews.

Approximately 50 percent of these patients (186 of them) asked for only one interview, and about 25 percent (98 patients) asked for two. The other 25 percent (99 patients) asked for three or more; this 25 percent accounts for 50 percent of the 766 requests (Table III).

The diagnostic composition of the group requesting interviews closely parallels that of the patient sample as a whole. No major diagnostic category is disproportionately represented. But some interesting divergences appear when the figures are anal-

TABLE III

DISTRIBUTION OF PATIENTS REQUESTING INTERVIEWS AND INTERVIEWS
REQUESTED IN TERMS OF NUMBER PER PATIENT (ON A RANGE OF 1 TO 9)*

Number of Requests per Patient	Distribution of Patients		Distribution of Requests	
	Number	Percent	Number	Percent
1	186	48.6	186	24.3
2	98	25.6	196	25.6
3	56	14.6	168	21.9
4	21	5.5	84	11.0
5	11	2.9	55	7.2
6	4	1.0	24	3.1
7	4	1.0	28	3.6
8	2	0.5	16	2.1
9	1	0.3	9	1.2
Total	383	100.0	766	100.0

*Average number of requests, 2 per patient.

alyzed in terms of the number of requests per patient.⁵ In the group of 99 patients who requested three or more interviews, the proportion of schizophrenics is 54.5 percent as compared with 40.0 percent in the entire patient sample. The proportion of psychoneurotics in this group, on the other hand, is lower than

5. The point of departure here for statistical purposes was arbitrarily set at three interviews because, while one or two interviews were often requested to discuss personal problems of a purely practical or administrative nature, requests in excess of two usually related directly to the patient's problems arising from his emotional or mental illness. Whether divided at 3 or more or at 4 or more requests per patient, the statistical differences were found to be insignificant.

In comparing patients requesting 3 or more interviews in the 3 diagnostic groups with the total number of patients in each subgroup, the difference was statistically significant at the 1 percent level ($.001 < P > .01$).

in the patient sample as a whole—15.2 percent as against 26.6 percent. There is also a slight drop in the proportion of patients with character and personality disorders, the figure here being 26.3 percent as compared with 28.3 percent in the total patient sample (Table IV).

TABLE IV

REPRESENTATION OF DIAGNOSTIC CATEGORIES IN GROUP REQUESTING INTERVIEWS
AND IN TOTAL PATIENT SAMPLE

Diagnostic Category	Representation of category						
	Patients Requesting 1 or 2 Interviews		Patients Requesting 3 or More Interviews		Total Group Requesting Interviews		Total Patient Sample (N = 576)
	No.	%	No.	%	No.	%	%
Schizophrenic reaction	98	38.7	54	54.5	152	43.2	40.4
Character and personality disorder	70	27.7	26	26.3	96	27.3	28.3
Psychoneurotic reaction	79	31.2	15	15.2	94	26.7	26.6
Other psychotic reactions	6	2.4	4	4.0	10	2.8	4.0
Total	253 ¹	100.0	99	100.0	352	100.0	99.3 ²

¹ The names of 31 of the 284 patients requesting 1 or 2 interviews were illegible.

² Remainder are cases of acute situational maladjustment.

Thus the schizophrenics tended predominantly to seek out the doctor in multiple individual interviews. The psychoneurotics, better able than the schizophrenics to function in the group and less dependent on the one-to-one relationship, showed an opposite tendency. Although they requested first interviews in about the same proportion as the schizophrenics, they were less inclined to repeat their requests. The patients with character and personality disorders showed a slightly different pattern from either of the other two categories. The proportion requesting one interview was slightly lower than for the schizophrenics and the psychoneurotics. But a relatively large number of them requested two interviews. After the second interview, unlike the schizo-

phrenics, the proportion requesting further interviews dropped off. It was as if the patients in this category were testing out whether the doctor could be trusted to see them, as the list on the bulletin board implicitly promised, and it took two tests to convince them. It was as if they were saying, "I'm from Missouri." The schizophrenics, on the other hand, returned repeatedly for the support which they sought in the individual interview with the doctor.

This breakdown of the figures suggests that the device of the doctor's list in the therapeutic community did not, as might be feared, open the floodgates to the "psychopaths" and the "troublesome neurotics." It rather opened the door to people in trouble, and the patients used it in proportion to the trouble they were suffering.⁶

Factors Determining Volume of Requests. The number of patients who signed the doctor's list fluctuated widely from day to day (Graph 13, Appendix D).⁷ For a time it was my impression that these fluctuations reflected the degree of tension on the ward. But careful study of them over many months indicated that this was not an adequate explanation. The peak points in the volume of requests coincided only occasionally with periods of high tension. Variations in the length of the doctor's list must therefore be explained primarily in terms of other factors.

Some of the variations are undoubtedly related to the varying admission rates. A comparison of the data reveals that the peak days on requests were frequently also peak days on admissions. This probably means that many of the new patients, seeing the doctor's list, wanted an interview with him to clarify their status or to discuss their personal problems. In natural likelihood, also,

6. This experiment, however, was confined to patients who stayed on the ward a short time. The results might be different in state hospitals with chronic patients, some of whom might importune the doctor for an interview every day. I cannot say positively how I would have met this situation.

7. This graph shows predominantly three types of curves. Type 1 has a high Monday peak and a secondary midweek rise. Type 2 has a low Monday peak and a high midweek peak, while type 3 has two equally high peaks. The large number of requests on the fourth Sunday in January is related to my being Officer of the Day and working in my office on the ward.

more disturbed patients would come onto the ward when admissions were heavier than at other times; the anxiety that their presence aroused on the ward might account in part for the frequent parallel between peaks on requests for interviews and peaks on admissions.

But perhaps an even more significant factor was the transfer of patients from the ward. With few exceptions the greatest number of transfers each week were made on Monday and the next largest number on Wednesday. Few were made later in the week and none on the weekend. The peaks on requests for interviews so frequently coincide with or immediately preceded the peaks on transfers as to suggest a direct cause and effect relationship. The parallel doubtless reflects the considerable anxiety of the patients about when they were to be transferred, where they were to go, and what the outlook for them appeared to be both in terms of their further stay in the hospital and the final disposition of their cases, as well as a need to relate personally with me for one final interview.

Graph 14 (Appendix D) shows the volume of daily requests for interviews in relation to the volume of admissions and transfers for 2 months. By and large, the greatest number of patients requested interviews either shortly after being admitted or shortly before being transferred. The explanation for this probably lies in the fact that many of the interviews were sought for the purpose of discussing personal problems of an administrative nature, and such problems were uppermost in the minds of the patients at these times.

Those peaks in the number of requests which do not coincide with the peaks on admissions or the peaks on transfers are exceptional. They usually relate to the presence on the ward of extremely disturbed patients or to discussion in the community meetings of subjects that aroused anxiety.

Content of the Interviews. It was known on the ward and often repeated in the community meetings that personal questions of a strictly practical and administrative nature were to be brought to me in individual interviews, rather than in the meetings. Many of the interviews were requested, therefore, for the purpose of discussing such matters. The patient wanted answers

to questions concerning his stay in the hospital, his diagnosis, or the disposition likely to be made of his case; or he wanted help and advice on urgent personal or family problems of a practical nature. Patients hoping to be sent from the admission ward to an open ward often wanted to ask me about their chances of this; and in many instances it was possible to assure them that their chances were good because of the improvement they had made during their stay on the ward. Patients who were in disciplinary status almost invariably came to ask what would happen to them. Since this was a matter of doctor-patient concern, the question was always answered within the limits and as precisely as possible. For the most part, the patients who requested only one or two interviews were concerned with problems of these types.

Situations which troubled patients on the ward also occasioned a number of requests for interviews. For example, a patient with a severe character disorder came in to tell me about his fear of one of the schizophrenics, especially at night, and his apprehension about the coming night. While nothing could be done except talk about his fear, the very fact that he could talk it out helped him to carry on.

Requests for sleeping pills were frequently made in individual interviews. In such instances I explained our policy of using them only in emergencies and led the patient to talk about why he needed them. Almost invariably he accepted the refusal without dissent and turned to his real anxiety. Often he left the interview with the satisfaction of understanding something of the underlying cause of his sleeplessness.

On occasion the doctor's list served as a safety valve in the case of severely depressed patients. In one instance, when an important person had promised to see such a patient and had forgotten it, the patient placed his name on the list. He had said to a staff member, in a tone of urgency and fear, "I'm really down today and I hope I can snap out of it." He remained by himself on the ward, and when the staff member came to sit by him, he walked away. In the interview his first words to me were, "I know what my trouble is—I walk away from people," (and implying that other people walk away from him). "Staying by myself is the worst thing I could do. I know I should be in

the group. I listened yesterday and wanted to talk. But I'm afraid of appearing stupid."

He went on to talk of his mother (an "ideal mother") and his wife. His mother had always told him what a difficult and painful birth his had been and how she had almost lost her life when he was born. When his wife became pregnant, he thought that she would suffer as his mother had. He became greatly depressed and was hospitalized for psychotic depressive reaction the day before his wife gave birth to the baby. In the interview he was able to see his own identification with his child, and the understanding relieved his anxiety considerably.

The interviews sometimes related to the discussion in the community meetings. For example, one patient began his interview by saying, "I brought up the question of failure in the service in the meeting [this morning] and I've been quite tense ever since." He went on to talk of his lack of self-confidence and of his father telling him when he went into the service that it would either make him or break him. He took his present situation as a grim fulfillment of his father's words, words he considered as evidence of threat of parental abdication and failure, a sort of foster-home-too-late.

Since he had reached only the point where his problem had mobilized anxiety, but not the point where it was meaningful to him, I urged him to bring it up in the community meeting. The next day he did so. In this instance, as in many others, the interview served to reassure the patient and to give him the confidence to take up with the group a problem that had meaning both for him and for them.

Other patients would confess in individual interviews things they had not told in their admission interviews or in the community meetings. One patient told me, for example, "I tried to shoot myself," a fact which he had withheld before. He had come to me, however, because of anxiety aroused by a situation that had happened on the ward. He had asked the Officer of the Day on sick call at night whether he could talk to him later, and the Officer of the Day had said that he would come back in a half hour. The patient told me, "He never came back. That was 18 hours ago, and I still have a headache." I gave him some

aspirin, and he was satisfied with that; but, more important, he was satisfied that he had been seen here as promised and when requested. It was this and the doctor's gesture rather than the aspirin that made him feel better.

Though the main purpose of these meetings was not psychotherapy, the plan of access to the doctor permitted minor psychotherapy which was more effective than drugs in diminishing the patients' anxiety, from whatever cause it arose; and actually, from an operational point of view, it took no more time.

SPECIAL TREATMENT (PSYCHOTHERAPY) CASES

One patient in each of the groups, selected at random, was seen daily in individual therapy during his stay on the ward.⁸ This plan was designed primarily to give me a deeper understanding of the operation of the group process through observation of its effect on the individual patient. It was also a means of keeping a finger on the pulse of the ward, for the special therapy cases were a continuing source of information on what the patients were thinking and saying about life in the therapeutic community.

The following aspects of life on the ward were apparently often discussed by the patients on the ward and were viewed with great favor: the accessibility of the doctor through the doctor's list; the elimination of the quiet room, which the patients feared and regarded as a form of punishment; the practice of seeing patients immediately on admission; the practice of transferring them from the ward in the order of their arrival; the concern and helpfulness of the corpsmen and nurses; and the daily community meetings.

The meetings seemed to have something of the interest of a daily newspaper on the ward. A comment made or a record played at a meeting often started a chain of thought that went on for days, and the patients talked among themselves about the ideas stimulated by the meetings long after the meetings had ended.

8. These were in the main 30-minute sessions, but because of the pressures and demands on the ward the time occasionally had to be reduced, sometimes to only 5 or 10 minutes.

The patients seen in daily individual therapy also gave me some valuable insight into silence in the meetings. For the most part, these patients themselves tended to be very guarded in the meetings and often did not speak at all, for they were very sensitive as to the effect that what they said in the meetings might have on the individual relationship or vice versa. But, I found, they all had vicariously participated, even though they had not spoken, and they all had a vivid sense of what had gone on. As one patient said, "My mind was going clickety-clack, clickety-clack even though my mouth was closed." Possibly there was a similar form of participation and identification going on in silent patients who were not seen in individual therapy.

The patients selected for continuous therapy often tended to act as if they had a special status, which indeed they had. But the fact that one patient in the group was being given this special treatment was never discussed by patients in the meetings, and no questions were asked about why he was being seen without having signed the list. It seemingly aroused little jealousy or resentment in the other patients. It was never mentioned by other patients who sought individual interviews by way of the list.

One of the special treatment cases—a 22-year-old Marine named Fogel—will be briefly discussed here to illustrate the interplay between the individual therapy sessions and the community meetings. This patient's story, as it came out in the interviews, was one of life-long conflict with a hostile, aggressive, alcoholic father who had beaten him savagely and repeatedly for as far back as he could remember. He told me, "My father never treated me well or helped me in a friendly fashion. My father always said I'd be a no-good bum." He had found a friend in his mother's brother, however, and he described this uncle as "everything a father should have been." His mother appeared in his account of her as a lovable person who deprived herself for the children and tried to protect them from the father. His childhood world was shadowed by the clouds of parental sadomasochism, and his ambivalent love for his mother caused him torment.

When the patient was 18, a very significant event occurred. The father, while drinking, tried to find a gun to kill himself,

and the boy hid the gun to prevent this. Police were called, and later the father beat the boy brutally. The boy never attempted to protect himself from the father's blows except by holding his hands in front of his face.

When he was 20, he joined the Marines to get away from the father. He made a marginal adjustment for 10 months, but then went AWOL in resentment over a 2-weeks' restriction imposed for disobeying an order to clean a rifle, which he claimed had already been cleaned. A few months after this, he married; and two months later, while he was on duty overseas, he received notice that his wife was filing for a divorce. At this point he became depressed and tense, developed generalized urticaria, and was admitted to the hospital. He was advised at this time to see a psychiatrist but refused.

After returning to his duty station, he applied for a humanitarian discharge because his mother, who was now divorced from the father, was in financial need. His application was denied, and he "blew up" at the noncommissioned officer, but the next day he came back and apologized. Following this, in a position of minor command, he would push his men too hard and then apologize. This behavior of aggression and then apology repeated itself until such time as he could no longer tolerate his anxiety and tension and was admitted to the psychiatric ward.

I first saw this patient in individual therapy on the afternoon following his first meeting on the ward. He had not spoken during the meeting, but had watched and listened carefully. In this first interview he said to me, "You know, Doc, I don't hate anybody. I just can't—I'm not made that way. I can't hate nobody at all, Doc. I can get sore and sock a guy, but then I will apologize and be sorry. I can't stay mad at anybody at all. Is that normal, Doc?"

"Are you sure you can't hate anybody?" I inquired.

"No," he insisted, "I can't hate nobody at all, not for any length of time, and if anybody is good to me and does anything for me I'd like to give them the shirt off my back. When I was overseas and this guy wants five bucks, I give it to him. If anybody does anything for me, I would do anything in the world for him."

"Are you thinking of anything special?" I asked.

"Yeah, this guy—" and then he paused and said, "My uncle, he says I'm all wrong, but if you would do something for me like helping me, now—like you're doing—and you wanted something—say a dollar—and it was between me and chow, I'd give it to you. Is it wrong to want to do that?"

"I think the intensity of your feelings is quite striking," I commented. "Isn't it better for us to try to understand why you feel so strongly, rather than what is right or wrong about what you want to do in this matter?" And then, tying the individual interview in with the community meetings, I said, "Do you remember what someone said in the meeting this morning—that it is possible to give and not expect anything in return, but that sometimes the expectation of getting something back can be very great?"

"Yeah, I know that."

All during the interview he sat forward in the chair, twisting a rubber band about his fingers and making quick, uneasy movements with his mouth. He constantly indicated his passive dependency by such queries as, "Is that normal, Doc?" and "Is it wrong to want to do that?" and by his need to deny his great hatred and his possibly unconscious aggressive and even murderous feelings.

In the next day's meeting again this patient said nothing. The meeting began with a 10-minute period of silence, which I interrupted by saying, "I wonder what this silence means." One patient replied, "Nobody has any problems." There was laughter at this, and when it had died down a schizophrenic patient said, "I slept well last night; the talk did it." Soon several patients talked about their personal problems, and then toward the end of the hour I played a short phonograph record about a little boy who ran to the top of a playground slide with an ice cream cone in his hand. There were many children behind him, yelling for him to go ahead. But if he went down the slide he would lose his ice cream cone, and the way back was blocked by the children behind him. Utterly frustrated, he began to cry and call for his mother, who says "I'm coming" as the record stops. There was considerable discussion in the group of this little situation.

In his interview that afternoon Fogel took pains to show me that, while he had been silent in the meeting, he had been listening. "You know, Doc," he said, "while the record was being played I kept thinking about something that happened when I was six, on Christmas Day. My father gave me a toy submarine and I was playing with it in the tub and spilt some water, and he came up and hit me and smashed the submarine and locked me in the attic. I broke out and fell down over the banister and hurt myself. My mother came and got me. I wanted to say something about it in the meeting, but I didn't like to."

"Perhaps you were ashamed of your father," I suggested. He said, "Yes."

In the next day's meeting the discussion dealt first with the subject of suicide, introduced by a patient who had just been admitted after threatening to jump off a bridge. What he really wanted, he said, was to go home and be with his wife. Another patient asked, "If you can't face it here, are you ready to go out?" There was a long silence after this, and then someone made a comment about what being "crazy" means, and the discussion turned to this subject.

Suddenly, toward the end of the hour, Fogel spoke up for the first time, "They figure I'm a nobody. Nothing is wrong with me. I don't belong here. I just have to get out and help support my family."

I asked, "Isn't there some reason why you are here?"

"Well," he replied, and hung his head, "I was having trouble and not getting along."

On the following day the question of "security" was brought up in the community meeting. One patient said that it was a matter of money, but that money doesn't always mean happiness. At this point they got onto the subject of giving, the subject with which Fogel was so deeply concerned in terms of the father who had never been able to give him anything but whippings, and he himself would give "the shirt off his back" for kindness (i.e., love).

One patient said, "Giving is affected by the giver and the manner of giving. If I gave you a gift, you'd have me pegged in the right ward" (meaning that it would be a crazy thing to do)

"but if I gave my father a gift, it would be another thing." Another patient said, "Gifts should come from the heart." Then Fogel said, hesitantly, obviously directing his comments to the patient who had implied that it was crazy to give (and probably feeling the emotion aroused by the word 'father'), "If I give you a Cadillac, you might crash it up and wouldn't care as much as if you had earned the money and slaved for it."

Realizing that Fogel was talking on this fantastic level about his own problem, I quickly brought it to a more realistic level by saying, "I wonder if we shouldn't talk about something more likely to be given."

As I said this, Fogel looked, and I thought longingly, at my watch. I turned my arm and looked at my watch too, and then he said that his father had given his brother (the favored brother) a wrist watch last month. Another patient said, "I once gave my father a gun." Fogel flinched perceptibly and became silent at this. At the very end of the hour, however, he spoke again, telling how he had once quit a job and had said angrily to his "rich boss" when he left, "Your money won't get you your youth!"

That afternoon he began his interview with further details on how he had "told off" the rich boss. In this verbalization he soon saw that he did feel hostility toward the man he was talking about and that in reality he could and did "hate" somebody. He suddenly recognized in this interview too that "somehow or other" I reminded him of his uncle. I had therefore, I thought, become the "good father" for the time being.

The following day's meeting is pertinent so far as Fogel is concerned only in that he was aroused in it to an intense hostility toward another patient who had spoken angrily to me. In this interview he said, "I wanted to punch him in the nose for being discourteous to you." He remained angry for two days about this, and he was also angry with me. "If anyone talked to me like he did," he said, clenching his fists, "I would punch him in the nose—or walk away." However, because of his own passive aggressive conflict, he also rather envied me for being able to control my anger. "That's my problem," he said, "about being under control."

During his last three days on the ward, he began to have extremely ambivalent feelings about leaving, and he did not talk any more in the community meetings. But in individual interviews he began to ask, "When can I leave this ward?" When pressed for the meaning of this, since he knew perfectly well when he could leave the ward, he said, "I'm afraid that my outbursts will land me on a locked ward." That is, he feared that, either by his verbal expression in the meetings or by some aggressive outburst against the patient who aroused his antagonism, he would stir his father surrogate to punish him and lock him up as his real father had done on that Christmas Day when he was six.

This patient ritualistically wrote his name on the doctor's list each day because he thought that the other patients would wonder why he was being called when his name wasn't on the list. He told me, however, that the last time I had checked his name off, I had made a "wiggly line" through it, which he thought was a question mark, and he interpreted this as saying that I didn't understand him (his transfer he interpreted as rejection). At the end of the interview he again reiterated his fear that his outbursts would get him onto a locked ward, and he said as he left my office, "I'll watch myself tomorrow, I promise, Doctor."

In the meetings he did not seem to be afraid of what he was saying, but when confronted with me in the individual interviews he was afraid of what he had said in the meetings, so strong was his need to be liked, so uncertain was his adjustment with a significant older man alone. Now his fear of rejection and the anxiety of separation began to take hold of him, and the following day, when I was unable to see him at the usual time, he waited all day by the ward door for me. I was able to see him then for only a very short time, and that night he had a sleepless night and a headache which persisted until the next day's interview, which was his last one on the ward.

At this last interview, instead of talking about pertinent feelings about himself and me, he talked about his wife and about wanting to get together with her again. He was afraid that the medical board before which he would probably appear would not

let him out of the service, a fear that was unfounded in reality, just as it did not seem that in reality he wanted to get together again with his wife. But this was not interpreted. The only things that I dealt with in this interview were the headache and the insomnia following my failure to see him at the regular time and for the full time. After this was discussed, I asked him about the headache, and he repeated, "Headache?" It was gone.

In the 10 days that this patient had been on the ward the decrease in his tension, anxiety, and depression was strikingly obvious. The therapy in the meetings and in the individual interviews had woven back and forth, and the symptomatic improvement which resulted was out of all proportion to the actual amount of time spent with him individually or in the group.

CHAPTER V

MEDICATION: BARBITURATES AND ATARACTIC OR "TRANQUILIZING" DRUGS

Certain attitudes that had a determining force in shaping our policy on medication should perhaps be defined at the outset. The Oakland experiment was not anti-drug. But dependence on external forms of control, whether drugs or harsher restraints, runs counter to the basic principle on which a therapeutic community operates—the principle that the major objective of management with the mental patient is to foster self-control. Since the patient can develop self-control only by facing his problem and learning to live with reality, the emphasis in the therapeutic community is on the social process which helps him to do so. When drugs facilitate this process or reinforce its effects, they are a valuable adjunct to therapy; when they have the opposite result, they are worse than useless. The instances in which we used medication, therefore, were determined largely by these considerations.

No rigid design was imposed on the experiment for purposes of evaluating the effects of the social process as distinct from the effects of medication, for we were not attempting to demonstrate that a therapeutic community could operate without the aid of drugs. We were concerned only with the therapeutic needs of the patients. If medication for a patient was felt to be in his best interests, or even in the best interests of the ward, it was prescribed. In other words, the experiment was not so "precious" that the fundamental function of the doctor was in any way jeopardized by a rigid adherence to a research design.

On the other hand, we conscientiously avoided the error of assuming that drugs in themselves can perform some miracle on the mental patient. Medication is likely to be as futile a device

as quiet rooms and mechanical restraints unless, with the direction of the therapist, the patient is led to analyze the causes of his tension and anxiety and to find within himself the necessary means of control. This was the function of the social process in the therapeutic community. The primary function of the medication employed was to facilitate this process.

BARBITURATES

The effects of the barbiturates have long been scientifically understood, and our policy on them was simply one of putting into practice existing knowledge. Our use of these drugs was negligible. The amount of sleeping medication prescribed was greatly reduced as compared with previous usage on the ward, and the use of parenteral barbiturates was practically eliminated. In the last 4 months of the experiment, a period during which 443 patients were admitted to the ward, only 24 doses of barbiturates, oral and parenteral, were given. This contrasts with 314 doses given to 440 patients during the 4-month period immediately preceding the establishment of the therapeutic community. The very few instances in which I used parenteral barbiturates were situations of extreme emergency, not run-of-the-mill situations.

But because of the routine practice of heavily sedating patients being transferred from one hospital to another, we had ample opportunity on the admission ward to observe the effects of barbiturates. This practice is, no doubt, reassuring to the non-psychiatric staff who transport the patients (or perhaps even to the psychiatrists). The effect on the patients, however, is less reassuring. It was our observation that large or small doses of barbiturates make the schizophrenic more confused and disoriented, more at the mercy of his hallucinations and delusions, and more at a disadvantage in dealing with reality because of the pronounced degree to which they cloud his consciousness and perception (even though, of course, their use may sometimes be necessary). They also seem to make him less amenable to psychotherapy. Although, in terms of intensified symptoms, the effects are most obvious in the schizophrenic, it was also observed that the neurotic and character disorder patients often deeply resent

this type of treatment as totally unnecessary with them, and their resentment carries over into the new hospital situation to which they are being transferred.

The antitherapeutic effect of the barbiturates on the intellectual processes is illustrated by the following instance. A patient who had been given an intramuscular injection of sodium amytaL and brought to Oakland in a strait jacket said to me in an interview a few days later, "Sir, do you believe in goblins, or was it the medicine they gave me?" I suggested, "Sometimes our imagination plays tricks on us." Then, answering his own question, he said, "Yes sir, I think it was my imagination. They brought me here in a strait jacket. I thought the goblins were all about me. I no longer feel that way."

We also had ample opportunity to observe that the common practice of sedating disturbed patients immediately upon their admission to the hospital may be an injudicious one. When a patient is brought into the hospital in a highly disturbed state of mind, in great tension and behaving bizarrely, there is a tendency for the staff to take the easiest way out of their difficulty by putting him to sleep. While this can be done dramatically by the use of intramuscular or intravenous barbiturates, and in rare instances perhaps should be done, it sometimes leads to antitherapeutic results. This is strikingly true in the case of patients with severe hysterical or conversion symptoms, where the memory of recent events is of extreme diagnostic and therapeutic significance. The act of expediency in such instances is a costly one in terms of subsequently trying to unravel the circumstances which precipitated the symptoms, for the drug-induced sleep often blots out all memory of what has happened. Thus a golden moment of diagnosis and therapy is lost by the failure to interview immediately and obtain as much contact with the patient as possible before amnesia sets in.

In one rather typical instance a patient was transferred to our ward from a civilian hospital to which he had been rushed for reasons laconically stated in the hospital's note to us as "violence and blackout and vomiting aboard bus." He had been put to sleep immediately with intravenous sodium amytaL in this previous hospital, and when he awoke on our ward he denied all

memory of any of the events immediately antedating his hospitalization; nothing specific could be learned from him to aid in his diagnosis and therapy.

The records accompanying patients admitted to the ward often indicated a rather obvious cause and effect relationship between the use of the quiet room and the use of barbiturates.¹ In the quiet room patients become even noisier and more violent than before, perhaps because of increased fear or perhaps in retaliation against the staff. Then they have to be sedated. And, since sedation makes them more confused, more disturbed by a sense of unreality, more hallucinatory and delusional, and less responsible to directions, they now become even riper victims for the quiet room treatment. So the thing becomes a thoroughly vicious circle.

Sleeping Pills. Too often, I suspect, the wholesale distribution of sleeping pills on the hospital ward is a measure taken to allay the anxiety of the staff and safeguard the doctor's sleep rather than to benefit the patient. It was our experience that the patients need them far less often than would be indicated by observing common hospital practice in this regard. Even patients who had been regularly given sleeping pills for a month or more before their admission to the ward, we found, got along quite well without them after a restless night or two. Moreover, with the help of the therapeutic community, they were often able to worry through the problems causing their insomnia and to arrive

I. The frequent practice of hiding acutely disturbed patients away in the quiet room when it is necessary to give them medication should perhaps be touched upon here. It is a practice that greatly increases the anxiety of the other patients, as I once had occasion to observe in a group meeting on another closed ward in our hospital. The patient in this instance had refused to take his reserpine and had been forcibly removed to the quiet room by seven corpsmen to be "tranquilized." There was considerable noise in the quiet room while he was being given the injection. Then he was returned to the ward, where he lay on his bed, sick and vomiting, during the meeting. Though the doctor in charge of the ward explained to the group that this patient was "so afraid that he wouldn't take his medicine," the reaction of the other patients was one of visible anxiety over what went on in the quiet room, out of sight, when a patient was forcibly dragged there to be given medicine. Moreover, if he was so afraid, what they had seen was indeed terrifying and hardly designed to allay fears. The discussion of the hour revolved almost exclusively around the question, "When do I go home?" This instance clearly illustrated for me the significance of what happens out of sight and the importance of administering medicine openly on the ward when it has to be given forcibly.

at relatively constructive solutions. In dealing with the problem of insomnia, as with behavior problems on the ward, we asked patients to stand up to the strength existing within themselves.

No standing order for the routine administration of sleeping pills was ever issued in the therapeutic community. They were prescribed only in special instances for extremely disturbed patients. A nightly sleeping pill was prescribed, for example, for several days for one patient with a post-encephalitic paranoid psychosis. Barbiturates and reserpine were also given sometimes for the first few nights to chronic alcoholics on the verge of delirium tremens; this condition in the very acute state did not seem amenable to the therapeutic community process, and medication was given in the hope that the other patients would not be kept awake. But no wholesale distribution was made, and the patients were never sedated into total lethargy. I remember one night as Officer of the Day, visiting our ward at 1:00 A.M., seeing a patient with delirium tremens pacing the ward, occasionally calling out to imaginary people outside the window; the FBI, he said, were out there and there was a gun fight going on, robbers were escaping. The phantasmagoric play of wild scenes kept him in an agitated state. Worse still, he seemed to feel responsible for a whole series of unrelated crises and began banging on the screen. Yet neither the other patients nor the night corpsmen seemed particularly concerned. I walked through the ward, and then sat there for 15 to 20 minutes. No one came to complain. Except for the one patient it was quiet and restful.

If a patient asked for sleeping pills, I explained our policy and discussed the problem of dependency upon medicine, and led him on to speak of his specific problems. In one case, for example, a new patient came to me to request sleeping pills, saying that he had had them every night for the past month in the hospital from which he had been transferred to Oakland. I explained that we did not give them on the ward except in emergencies because of their tendency to be habit-forming. Though I spoke in generalities, he immediately interpreted what I had said in terms of himself and he accepted the refusal with good grace. When I saw him the next day, he told me that he felt less tense than he had for a month past. His explanation of

this was, "After I went out of your office, I reasoned a lot of things out for myself for the first time, and I felt more relaxed." This patient never again asked for sleeping pills or complained of insomnia.

On occasion, however, patients became quite threatening when they were told that they could not have sleeping pills, particularly patients with severe character disorders of a psychopathic type. One such patient threatened after my refusal, "Well, some of your corpsmen are gonna be messed up." This was spoken in the presence of the corpsmen, and was clearly intended as blackmail. I told him firmly as a statement of fact, "We don't talk like that on this ward, and nothing is going to happen to the corpsmen." And nothing did. He was trying me out to see how far I could be pushed, and he was satisfied that he had "cased the joint." We had no further trouble from him.

In a similar situation, a paranoid schizophrenic patient demanded a sleeping pill from the nurse. She told him that the doctor hadn't ordered one for him and that he would have to go to bed and try to sleep without it. He then repeated his demand of the corpsman; and when it was again refused, he grabbed the corpsman and started to shake him. The nurse stepped between them and said, "We don't handle the corpsmen that way here." The patient returned to his bed, and the following morning in the community meeting he apologized to the entire group for shaking up the corpsman.

On one occasion I was awakened at my home at 2:00 o'clock in the morning by the nurse calling (after having first called the Officer of the Day without satisfaction) to tell me that a paranoid manic patient was keeping the ward awake and that she felt helpless. (She also, quite obviously, felt angry.) I told her to give him three grains of sodium amytal by mouth, but a few minutes later she rang back to say that he refused to take it. I then called the corpsman and told him that I was coming in to the hospital and asked him in the meantime to get the patient into my office and try to persuade him to take the pill. When I arrived, the patient had taken the medicine and was asleep. The corpsman, who was feeling pleasantly and justifiably self-confident over his success in handling the situation, told me that the

TABLE V

USE OF BARBITURATES ON THE ADMISSION WARD FROM MARCH 1955
THROUGH MARCH 1956¹

<i>Number of Admissions</i>	<i>Nembutal gr. 1½</i>	<i>Seconal gr. 1½</i>	<i>Amytal gr. 3</i>	<i>Sodium Amytal gm. 0.5 IM</i>
1955 (prior to therapeutic community)				
Mar.	128	23	18	19
Apr.	116	40	6	19
May	99	18	27	10
June	97	52	31	3
	<hr/> 440	<hr/> 133	<hr/> 82	<hr/> 51
(Transition month)				
July	79	43	10	1
(Therapeutic community)				
Aug.	91	7	9	1
Sept.	90	5	16	0
Oct.	86	5	1	0
Nov.	100	0	2	4
	<hr/> 367	<hr/> 17	<hr/> 28	<hr/> 5
Dec.	102	0	1	0
1956				
Jan.	127	0	5	2
Feb.	86	0	4	1
Mar.	128	0	4	2
	<hr/> 443	<hr/> 0	<hr/> 14	<hr/> 5

¹ Figures taken from nursing log. In addition to the above, 1 injection of sodium phenobarbital was given in March 1955 and 1 in March 1956. Phenobarbital gr. ½ was given largely in cases with epilepsy after July 1956, a total of 145 tablets in all. In the preceding 4 months, 58 tablets were given. A total of 1 cc of Nembutal was given after July 1955, and no sodium amyta gr. 1½. Total number of patients during entire study: 939 (July, 79; Aug.-Nov., 367; Dec.-March, 443; part of April, 50).

patient's attitude changed when he knew that I was on the way, not because he was afraid of me but because he was impressed at my being enough concerned over him to take this amount of trouble. He told the corpsman, "I'll take the pill, you can trust me." Care of the patient, it has been said, is a matter of caring for the patient. And this often means caring enough to lose our sleep

over him rather than taking the harmful precaution of indiscriminately handing out pills. It was not the barbiturates in this case but the social forces which carried the day, and made sedative action possible.

Table V compares the use of barbiturates on the receiving ward during the 4-month period preceding the establishment of the therapeutic community with their use during two 4-month periods following its establishment. (See also Graph 15, Appendix D.)

ATARACTIC DRUGS

The effects of the ataractic drugs, unlike those of the barbiturates, are not yet fully understood. Our use of them, therefore, was necessarily more experimental. But we were not attempting to establish large scientific truths about these new drugs, for the therapeutic community project was not a drug research project. Our approach to them was simple. We asked only one question: Would they facilitate the therapeutic process of socialization, especially in the hyperactive psychotic patients? This consideration determined our policy on their use. My observations, then, are not in any sense advanced as a definitive evaluation of the ataractic drugs. They deal only with the effects of these drugs in relation to the effects of the group process as noted in the therapeutic community experiment at Oakland.

The ataractic drugs employed in the experiment were chlorpromazine and reserpine. Over the entire period of the experiment 11 percent of the patients received chlorpromazine and 9.1 percent received reserpine. The average proportion of treated patients was thus approximately 20 percent of the total. The majority of the patients treated were psychotics. But, as psychotics made up 44.4 percent of the total patient sample, it will be noted that the number of patients treated with the drugs amounted to less than half of the total number of psychotic patients admitted to the ward.

Our use of the drugs began slowly. In the first 5 weeks of the experiment they were given to only 6 of the 123 patients admitted during this time, and in the first 4 months to only 43 out of a total of 399 admissions (see Table VI).

TABLE VI

USE OF ATARACTIC DRUGS (CHLORPROMAZINE AND RESERPINE) ON ADMISSION WARD
JULY 1955 — APRIL 1956

Month	Number of Admissions	Patients Given Drugs ¹		Number of Doses Given ²	
		Number	Percent	Total	Average per Patient Treated
1955					
July (last 7 days)	32	2	6.3	6	3.0
August	91	4	4.4	75	18.8
September	90	9	10.0	153	17.0
October	86	14	16.3	213	15.2
November	100	14	14.0	243	17.4
December 1956	102	20	19.6	306	15.3
January	127	38	29.9	630	16.6
February	86	24	27.9	410	17.1
March	128	40	31.3	621	15.5
April (first 2 weeks)	50	14	28.0	168	12.0
Total	892 ³	179	20.0	2825	15.9

¹ Does not include 6 patients given other ataractic drugs.² Average dose Chlorpromazine 100 mg., average dose Reserpine 1 mg.³ Total does not include all patients admitted in July.

During this early period the drugs were reserved for very special instances of highly disturbed psychotic behavior. Chlorpromazine was prescribed for hyperactive, aggressive psychotics with a history of violence; this use was, in a sense, a measure taken to remove a barrier to therapy by relieving the staff of their fear of such a patient and, in consequence, enabling them to relate to him and work with him more effectively. Reserpine was used with psychotic patients in whom anxiety and morbid fear were the predominant symptoms, rather than hyperactivity and hyperaggression, and with patients in acute states of delirium tremens and other deliriums. Neither drug was found to be of help with the depressed patients.

In the next 4-month period beginning in December treatment was extended to some of the less disturbed psychotics and a few of the neurotics to see whether a wider use of the ataractic

drugs would further benefit the community. In December an open receiving ward had been established. In the subsequent months our ward census was composed of a more obviously sick patient population for locked ward care. This, too, accounted for the larger percentage of drug-treated patients. As compared with 10.8 percent of the patients in the earlier period, 27 percent were now given the drugs. (The difference between the two periods in terms of these criteria is statistically significant at the 1 percent level—(.001<P>.01.) The average dose was the same in both periods—chlorpromazine, 100 mgs; reserpine, 1 mg—and the average number of doses per patient treated remained approximately the same—16.0 in the first period and 15.7 in the second.

Since we had neither the staff nor the time to set up objective techniques for precisely determining the effects of this increased use, the results can be reported only in terms of subjective observations. In general, this extension of the ataractic drug treatment made no appreciable difference on the ward in terms of the criteria by which we were constantly evaluating the therapeutic community. The tension in the community meetings was little different as judged by the amount of motor movement (number of patients leaving the group, going to the head or to the fountain, standing, crying, wringing their hands, etc.). The number of administrative problems and behavioral difficulties entered in my ward log shows no significant decrease. The number and nature of the requests for interviews did not change. There was no discernible change in the nature or content of the community meetings, and no drop in the number of barbiturates prescribed by the Officer of the Day. Moreover, a slight increase in staff tension was noted, revealed by such questions as who should be given medication and appeals for such treatment on behalf of patients who aroused anxiety in staff, and there was also a slight tendency to hope for too much from the drugs and to lean too heavily on their aid.

In terms of these admittedly impressionistic and qualitative criteria, the ataractic drugs appear to have been helpful primarily in managing the hyperactive, aggressive, and greatly disturbed schizophrenics, the manic-depressives in the manic stage, and patients in acute states of delirium. Except during the first

few weeks of the experiment, these types of patients were treated with drugs throughout the experiment. To some extent, also, they were helpful in treating the hebephrenic schizophrenic (largely, perhaps, because they made possible some empathy with this type of patient, rather than because of any changes they effected in the patients themselves). But with the nonpsychotic patients and the depressed psychotics, we observed no appreciable effect. The extension of the treatment to these types of patients, therefore, was of no additional benefit so far as can be judged from our clinical impressions and data on behavior. (In no instances were the drugs used for symptomatic relief of moderate anxiety or depression or for the type of symptoms which would be likely to bring a patient to the physician in ordinary practice.)

In the 10-month period of the experiment on our ward, we noticed no toxic effects from the drugs except for an occasional instance of Parkinson's syndrome in patients on chlorpromazine. This disappeared with a termination of the treatment or a reduction in the dose.

Though most of the patients treated with the ataractic drugs were schizophrenics, the use was not determined on the basis of diagnostic categories. Each case was evaluated individually in terms of the following considerations: (1) the "threat" which the patient's behavior and symptoms presented to the staff and the other patients and (2) the extent to which the patient's motor behavior (not his thinking) was distorted by anxiety associated with delusions of danger to himself or violence on the ward. Thus the drugs were prescribed for those patients whose behavior was a barrier to the social process; equally sick patients who were neither threatening nor seriously disturbing to the ward were not given them. In a number of instances the treatment was prescribed in response to an implicit or explicit demand from the staff or the patients to "do something" about a patient whose behavior they could not tolerate.

But the community not only determined the use of the drugs. It also influenced their results. For example, the mere knowledge that a difficult or threatening patient was being given drugs to control his behavior reduced the tension felt in the community in regard to him. As a consequence, both patients and staff were

able to approach him with more freedom and friendliness and to make him feel that he was a member of the group. The possibility that the modification in his behavior was as largely a response to this changed community attitude as to the medication cannot be discounted.

As a general truth about the ataractic drugs, as about the barbiturates, I believe it may be observed that the determining factor in their use is the staff's capacity to tolerate their own anxiety. The important thing is for all the staff to realize that it is usually for their sake that the patient has taken the drug, and they should not be misled into believing that it is only helping the patient. On the other hand, there is no reason for them to ignore the fact that, because the patient is taking the drug, their own attitude toward him is better, and that in the long run the patient's need for a specific useful therapeutic attitude from them may be so great that the price which the patient pays for it may be justified. In other words, if the patient's taking the drug relieves staff anxiety and thus enables the staff to relate themselves therapeutically with the patient, the ultimate gain to him may more than offset the real or potential loss.²

In many instances we saw changes for the better in patients treated with the ataractic drugs. But, since no special techniques were set up for determining the effects of the drugs as apart from the effects of the social process, the extent to which they were directly responsible for these changes cannot be precisely evaluated.³ The results must be analyzed in terms of the ongoing situation, rather than in terms of a situation created for purposes of pure research.

The clinical evidence, however, leads me to the conclusion that the drugs were not the determining factor in the improvements observed. They were of benefit in controlling motor

2. The situation seems to me analogous to that in which the question arises whether spanking a child is a good thing. Good for whom? The mother? Or the child? Sometimes it may be much better to permit the mother to spank the child than for her not to. Some mothers who withhold from themselves freedom to spank a child retain toward the child a sadistic attitude which is much more prolonged and painful than the spanking would be. If the spanking will make the total situation better (i.e., if the relationship of the mother to the child is bettered by it), then spanking should be permitted. It is in this sense that atar-

behavior or in changing types of motor behavior which prevented socialization between patients and between patients and staff. Thus they were a valuable adjunct to the major therapy. But the social and psychiatric factors operative in the group process appear to have been primarily responsible for the results achieved.

One type of clinical evidence which supports this conclusion is the fact that *patients with a history of violence were often handled adequately on the ward without recourse to the ataractic drugs.*

A case in point is that of a Negroid patient with a serious character disorder of an aggressive type who had spent his entire time in the previous hospital in the quiet room. On his first night there, in an argument over the radio, he had struck a corpsman on the head with a chair, inflicting an injury that required ten stitches. He was thereupon transferred to Oakland in restraints and heavily sedated, with an accompanying note describing him as a dangerous character, "subject to unprovoked rage and with both suicidal and homicidal impulses."

In his admission interview at Oakland he was not overtly hostile, though sullen, and was willing to talk about his difficulty at length. There was no evidence of psychotic thinking, but he was afraid of his own impulsive aggressive behavior and his distrust for people.

On the ward, the group process had an observably favorable effect on this patient's behavior. Under courteous treatment, and with no threat of the quiet room, his initial sullenness gradually gave way to friendliness, and he finally took an active part in the community meetings. Only one instance of potential difficulty ever arose with him, and this was when the nurse, not knowing that he was illegitimate, asked him in a community meeting why

ataractic drugs, by making the total situation better, may have their uses. The important thing is to recognize that in themselves they do not affect the patient's illness and cannot cure him. And, like the barbiturates, the ataractic drugs are an assault upon the patient's ego. This assault may, of course, be worth while if the total situation is improved. If you gain on the roundabout, there is no harm in losing on the swings, as long as you come out of the affair showing a profit.

3. A way of evaluating social and somatic therapy is shown in the significant experiments reported by Ackner, Harris, and Oldham. See *Insulin Treatment of Schizophrenia, a Controlled Study. Lancet, 1:607-611 (1957).*

he joked about the word "father." He turned to her angrily and said, "Why do you ask that?" But he controlled his temper and only became momentarily sullen and withdrawn.⁴ One night toward the end of his stay on the ward, there was an argument over the radio similar to the one in which he had behaved so violently in the previous hospital. But instead of attacking the corpsman, in this instance he merely announced, "I'm going to bring this up in the meeting tomorrow."

I saw this patient as a "special treatment" case in daily therapy sessions; his feelings about not having a father formed the basis of the major task.

In contrast to the previous hospital's experience with him, he was absolutely no behavior problem on the ward. This suggests that, possibly because of his racial status and his illegitimacy, the group process met a deep need in him and effectively controlled his behavior without the help of ataractic drugs.

A second type of supporting evidence for the view that the social process played the major role in effecting the improvements observed is the fact that *in many instances where ataractic drugs had been used previously in the conventional hospital environment to control the patient's behavior, their discontinuance was possible in the therapeutic community.*

In one such instance the patient, a schizophrenic who had suffered a psychotic break after one week in boot camp, had been placed on chlorpromazine immediately upon his entrance to the hospital. He had also been secluded; he spent the first four days and parts of each day thereafter in the quiet room. In telling me of his previous hospital experience in his initial interview at Oakland he said, "I hated the quiet room. I hated being closed up. I can't stand small spaces. For years I could hardly go into a bathroom without feeling smothered. When I was young I worked in a grocery store, and they would sometimes lock me up in a large refrigerator and turn the lights off to scare me. I'd nearly go crazy."

His claustrophobia, of course, was intensified in the quiet

4. The nurse in this instance committed a grave error in her reply, "Oh, no reason," because if she were asking such penetrating questions for "no reason" it was indeed a dangerous situation. I therefore actively intervened.

room, and his behavior deteriorated *despite* the ataractic drug treatment. The corpsman's notes describe him as crying, tearing his pajamas to shreds in an excited panic, and constantly talking about "hurting someone" and threatening, "I'm going to do some damage around here." In the quiet room he developed the delusion that the corpsmen were shooting him with electricity, and on one occasion when the door was opened he burst through it and had to be brought back forcibly. He feared that the quiet room had been wired and he expressed the delusion, "It will never hurt me as long as I touch someone." This seemed to me a very important communication of his desire for social contact and of his fear of being deserted and hurt.

He made an excellent adjustment on our ward, and the chlorpromazine, which he had been given for 15 days in the previous hospital, was discontinued the day he entered. In the therapeutic community, where there was no threat of the quiet room, he was a well-behaved patient, cooperating in the community meetings and in the social life on the ward. His delusions about electricity and about being hurt disappeared.

Perhaps an even more convincing type of evidence for the significance of the social process, as compared with the ataractic drugs, is the fact that *in many instances where the drugs had failed to control the patients' behavior in conjunction with conventional hospital practices, an observable improvement was effected when the therapeutic community process was added.*

One conspicuous example of this is the case of a patient who, within 30 minutes of entering the previous hospital, was given an intramuscular injection of chlorpromazine and 15 minutes later was placed in the seclusion room, where he remained for 14 days until his transfer to Oakland. The diagnosis in this case was schizophrenic reaction, hebephrenic type.

The use of the "tranquilizing drugs" so soon after admission, followed so quickly by seclusion, suggests a *fear of* the patient and a sense of urgent need to actively control him, though the record refers only to "uncooperativeness." Despite the use of chlorpromazine, his behavior as noted in this record was a caricature of the lunatic. He was described as belligerent, noisy, masturbating on the ward, tearing pillows, stuffing toothbrushes

and toothpaste down the toilet, giggling, banging on the walls and door of the quiet room, and screaming that there were snakes in the pipes and that a baldheaded woman was in the quiet room.

He arrived at Oakland fantastically bound to the litter, with leather cuffs on his wrists and legs, and sheets twisted into restraining bands around his chest and under his arms. From the moment his restraints were off, his hebephrenic behavior was so disturbing that there were at first practically no intervals of calm on our ward. After two days of this, it was decided to try the effect of reserpine. With the wildly acting, potentially violent type of aggressive patient our choice would have been chlorpromazine, but this patient's behavior was all in the hebephrenic pattern.

Obviously, no amount of ataractic drugs could possibly reach the cause of his psychosis and effect a cure. The drugs could at best ameliorate the bizarre manifestations and create a situation in which the therapeutic community, both patients and staff, could accept him and be accepted by him—could "bring him down to earth." There was evidence that the eruption of his bizarre behavior had coincided with his physical restraint in the brig, from where he had been removed to the hospital. The effort to control it with ataractic drugs used in conjunction with confinement in the quiet room had failed. *His need was to be brought out into the open and to be accepted into a group, rather than to be concealed in solitude.*

There was no dramatic symptomatic improvement in this case. But the social improvement was clear. And it could not be attributed to the medication alone, for the ataractic drugs had had no effect on his behavior in the previous hospital, where they had been used for two weeks in larger doses than we gave. It seems reasonable to assume, then, that the therapeutic community process gave it some potency that it did not have in the conventional hospital environment of quiet rooms and restraints.

This relation is further suggested in the case of a patient who had progressively deteriorated under treatment with chlorpromazine in a previous hospital but whose behavior rather rapidly improved when he was given chlorpromazine in the therapeutic community. In the previous hospital, the record

states that he was "unruly and unmanageable," and, despite the chlorpromazine, there was increasing evidence of hyperactivity, flight of ideas, pressure of speech, inappropriate affect, and impaired judgment. He was placed in the seclusion room, which intensified his delusional fears that someone was going to kill him or seriously hurt him.

On his admission to Oakland he was hallucinating constantly and was so obviously delusional that it was difficult for me to talk to him. The chlorpromazine treatment was continued immediately, and *within three days* he became manageable; he dominated the community meetings and was frequently verbally belligerent and antagonistic, but his hyperactivity decreased considerably. By the end of his stay on our ward his manic behavior and his flight of ideas had largely subsided, although his communications were still quite bizarre and there was euphoria.

I saw him in daily interviews, where he responded and seemed to understand simple, persistent interpretations. It was necessary to give him sleeping pills on two nights when there was tension on the ward due to the presence of a number of acutely psychotic patients, but he was neither "unruly" nor "unmanageable" on our ward.

Another patient, a delusional schizophrenic who had made a moderate improvement coincidental with treatment on chlorpromazine during the 10 days that he was on our ward, deteriorated markedly when he was transferred to another locked ward in our hospital, although the drug was continued there. He was returned to the admission ward for another 4 days. His symptoms again subsided and, on his return to the other ward, his improvement now continued.

In the following pages a number of case records are summarized for the purpose of illustrating our approach to the use of the ataractic drugs and our experience with them in various types of situations. But they also provide substantial further evidence in support of the view expressed here—that the improvements observed in the therapeutic community were never attributable to the ataractic drugs *alone*, or *even in major part*; the determining factor was the social process.

CLINICAL MATERIAL ON THE ATARACTIC DRUGS

In some instances where patients had had no treatment with the ataractic drugs before coming onto our ward, treatment was begun immediately if the patient's behavior was so hyperactive and hyperaggressive that it would create a barrier separating him from the staff; otherwise, the decision on their use was deferred for a few days' observation.

In instances where patients had previously been treated with the drugs, the treatment was in some cases continued, either immediately or after a few days' observation, and in others it was discontinued and not resumed during the stay on the ward. The decision was based almost exclusively upon my evaluation of the patient in the initial interview and in the meetings, rather than on the history of his behavior in the previous hospital.

In general, treatment was postponed wherever possible in order to observe first what effect the therapeutic community alone would have in modifying the patient's behavior and symptoms.

Since no matched control groups were set up of patients receiving the drugs and patients not receiving them, no comparison of the two groups on this basis is possible.

Case Record. (No previous ataractic treatment and no drug treatment on ward.)

This patient, a paranoid schizophrenic, arrived on the ward in mechanical restraints and heavily sedated. In his admission interview, he sat rigidly in the chair, staring at me expressionlessly and talking slowly and softly in a monotone about his delusions, auditory hallucinations, and ideas of reference. He was lost in a world of his own where he saw himself as part of some plan and where things were happening over which he had no control. Although this patient was considered sufficiently ill to be transferred in restraints, he adjusted satisfactorily to the therapeutic community and contributed to the meetings. He was not treated with the ataractic drugs.

Case Record. (No previous treatment; begun immediately on admission to the ward.)

The patient in this case was admitted to the psychiatric service

from the medical service, where he had been hospitalized with metastatic malignancy. In the hospital he had become seriously depressed and had made veiled suicidal references. On his admission to our ward he was suffering from a reactive depression, but it was not considered to be serious and he was not thought to be a serious suicidal risk. He was given reserpine at once. There was a remarkable improvement in his mood within 24 hours, and he became active, helpful, and friendly in the community meetings. The immediate use of reserpine, together with the therapeutic community, was so effective that he could be transferred back to the medical ward. Its use was dictated by the clinical impression that apprehension, fear, and anxiety were more important than depression.

Case Record. (No previous treatment; begun immediately on admission to the ward.)

This case illustrates how, with the help of ataractic drugs, a successful ward adjustment was often made in the therapeutic community by patients with whom the traditional methods of control with seclusion, restraint, and barbiturates had conspicuously failed. The patient, an extremely sick schizophrenic, had been in another hospital for 16 days, where he was described as "belligerent, provocative, assaultive," and given to urinating and defecating on the quiet room floor. Extensive neurological study was undertaken, which was negative, but for some reason ataractic drugs were not used.

On admission to the previous hospital he was given phenobarbital. Two days later he was put in restraints, and an order was issued for "paraldehyde, 3 grams h. s. by mouth," with instructions that if he would not take it he was to be given 6 cc's intramuscularly, to be repeated in two hours. Orders for sedative tubs and intramuscular injections were also issued. The corpsman's note on the first night states, "Patient has caused disturbance on the ward all day, jumping up and down and moving body in different motions. Attempted to put head in commode. Made attempt to run out the door when open for chow. Put in quiet room and was let out for shower. Started a fight and was placed back in quiet room by force. Given sodium amyta. Back in quiet room. Banging on door. Shot was administered."

In the quiet room he would stand on his head for long periods, saying that he "had to" do it, and would beat on the door and yell

out the window. He tried to choke himself, held his breath, and dug at his eyes until they bled. The corpsman's note on the patient's last day in the hospital reads, "Banging his head on the door. Had a goose egg at the hairline. Tub bath. Tried to break out of door. Urinated and defecated on the deck in the quiet room. Intramuscular nembutal 2 cc's."

In his admission interview with me at Oakland, he was markedly confused, though he was able to say, "I am not in my right mind." During the interview he talked to God, saying, "I'm not going to look at the finger again, God. I mustn't talk any more." Twice he suddenly stood up, threw himself completely around, and doubled both fists close to his body as if to frighten me. When I did not move, he sat down and was then courteous and friendly, though still suspicious. He was placed on 75 mgs of chlorpromazine, intramuscularly, t.i.d., and then orally, and made a slight but definite improvement. His urinary incontinence decreased and his fecal incontinence stopped completely. At no time was it necessary to increase his medication because of difficulties in managing him. He kept to himself for the most part and did not participate very actively in the community meetings.

Case Record. (No previous ataractic treatment; begun on ward after a period of observation.)

In this instance the patient was admitted to the ward directly from shipboard in a state of acute psychotic depression considered to be schizophrenic in nature. He had suddenly developed delusions of persecution, believing that "a ring" had been formed aboard ship to frame him on the charge of having stolen a large sum of money from the ship. He also believed that officers aboard ship had been murdered and that he was going to be next.

On admission to Oakland he thought that the same "ring" existed on the ward and that all the people on the ward were secret police and spies and killers. He struck two patients whom he accused of trying to frame him, and for two nights he kept many of the patients awake in fear that he would attack them on an irrational impulse.

In the first community meeting he was silent. Then the next day he communicated his delusions to the group. After this experience his whole delusional system reversed itself. Instead of "spies and killers and secret agents," all the people on the ward now became "relatives and friends" from his home town, and he no

longer struck anyone. But he was still just as delusional, of course, and he was noted also to feel more anxiety even though he now felt safe. The specific fears based on delusions had evaporated following an intrapsychic alteration in the delusions. With nothing to "hang" his affect on his anxiety was now free-floating. Thus after he had been on the ward for four days and his delusions had become "socialized," ataractic drug treatment was begun. It was continued through the rest of his stay on the ward because of this anxiety.

In this instance of an acute psychotic break, the socializing and therapeutic pressures of the milieu alone were highly effective in stabilizing and controlling the patient's irrational motor behavior, but it was felt that some additional help from medication was desirable. His dramatic improvement occurred before the drug was begun. It continued, probably aided by the drug.

Case Record. (Previous treatment; discontinued on admission.)

This extremely sick paranoid schizophrenic had been given small doses of chlorpromazine (25 mgs t.i.d.) for 10 days at the previous hospital without improvement. The note accompanying his transfer to Oakland described him as in an "acute paranoid state, exhibiting suspiciousness, inappropriate affect, marked delusions, and difficulty with speech." Among his delusions was the fixed idea that he was surrounded by Communist spies who were putting poison in his food and cigarettes, and that he would die at any moment. He also had the delusion that there was a fishbone in his throat. On his admission to Oakland, these findings were still manifest. He repeatedly demanded that I operate on him at once for the removal of the fishbone. It was significant that, in his interview with me, he attributed his troubles to the fact that when he had gone home on leave he had felt unwelcome by the community and especially by his mother. The importance of the social situation in this man's illness was reinforced by the fact that his parents were divorced when he was very small. He had lived with his mother (whom the neighbors, he said, considered "crazy or peculiar") until he was 14; he was then sent to a foster home and, at 16, to an orphanage.

He was not treated with the ataractic drugs on our ward because many of his paranoid symptoms were dramatically of a social sort, and control of his "thinking processes" by medication was considered a less effective approach than social adjustment with a

peer group and a father-surrogate. Moreover, he was under no appreciable motor tension, although anxious.

During his stay on the ward, his delusion about the fishbone remained unchanged. Yet he ceased to express his fears about Communist spies and about being poisoned, except at odd moments and then only half-heartedly. He adjusted satisfactorily to the ward without the aid of ataractic drugs, and contributed meaningfully to the community meetings.

Case Record. (Previous treatment: discontinued on admission.)

This patient was admitted to another hospital in disciplinary status for having verbalized his homicidal impulse and fighting with the military police. In the police station he had actually hanged himself by his belt, and when cut down had demanded to be placed in the brig. In the hospital the diagnosis of paranoid schizophrenic reaction was established. The record notes "marked suspiciousness, withdrawal, and paranoid ideas." It notes too that he had been kept in the quiet room for defecating on the deck, throwing feces, and being assaultive. He was given chlorpromazine (100 mgs 4 times a day) for 7 days, and when he showed no improvement whatsoever he was transferred to Oakland.

On admission to our ward he cried bitterly, expressing his wish to die and his feeling that people were laughing at him on the ward. He demanded, "Lock me up or let me out." I saw him briefly several times during the first day. During these interviews he frequently cried when he talked of his son, and his affect was quite inappropriate. He seemed to respond well, however, to direct and simple statements.

He was seriously upset only once, and that briefly, during his stay on the ward; when the matter which had agitated him was brought out in the community meeting, his anxiety diminished. The ataractic drug treatment was discontinued on the day of his admission and not resumed while he was on our ward. His behavior was no management problem in the therapeutic community. He was not assaultive and no longer defecated on the deck.

Case Record. (Previous treatment: discontinued on admission.)

Before coming to Oakland, this patient had been treated on the medical wards of another hospital for various psychogenic musculoskeletal reactions with aspirin, codeine, morphine, pheno-

barbital, and nightly sleeping pills. The symptoms were clearly of an hysterical conversion nature. Chlorpromazine was used for 14 days, but without effect. The pain and the insomnia continued. On his admission to Oakland he was extremely negativistic, resentful, and uncooperative. He complained bitterly at first because his sleeping medicine was discontinued, but after the third night he slept soundly. During his stay on our ward he was moderately cooperative; his complaints ceased; his insomnia disappeared; and his pain became tolerable. At no time was the thought of resuming ataractic drugs contemplated.

Case Record. (Previous treatment: discontinued on admission.)

This patient was admitted to a previous hospital with pain in the right arm and shoulder, insomnia, and anorexia. His final diagnosis there was depressive reaction and radicular neuritis. He had frequently expressed suicidal ideas. In the previous hospital he had been treated for 14 days with reserpine, in addition to numerous medications to control the pain and nightly sleeping pills. On admission to Oakland he asked for sleeping pills, but he accepted the refusal quietly and made no further complaints of insomnia. The ataractic drug and numerous medications for pain were discontinued and he made a good adjustment on the ward without them, and although his depression continued, the pain diminished.

Case Record. (Previous treatment: discontinued on admission.)

In this case the patient, an extremely paranoid schizophrenic, had been treated for one week at another hospital with chlorpromazine and had become progressively worse. He had the delusion that he was being poisoned by the medicine.⁵ He had been admitted to the previous hospital from shipboard because of feelings of persecution and bizarre behavior, and his behavior in the hospital was described as negativistic and belligerent.

5. The paranoid idea that the medicine is poison frequently complicates the problem of administering it. This delusion was often communicated to me at sick call or in the individual interviews. In the community meetings, however, it was almost never expressed, for the group gave it short shrift, despite their general tolerance for delusional communications. On the very few occasions when a patient said in the meeting that the medicine I was giving him was poisoning him, he evoked a series of staunchly indignant, favorable testimonials to the medical profession and the Naval medical corps. Such accusations were totally unacceptable

On admission to Oakland he was quiet, shy, and soft-spoken, and was no problem. In his initial interview he said that he felt that his mother neglected him and was "against" him. He attributed his illness to a tonsillectomy that had been performed after he entered the service, for it was at this time that he began to develop delusions and the paranoid feeling that everybody aboard the ship was "picking on" him. His delusions were predominantly oral. Each food had a special meaning for him; for example, "When they eat cookies, they are referring to my sexual organs."

Since he was under no motor pressure, the ataractic drugs were not given him on the ward.

Case Record. (Previous treatment: discontinued on admission.)

Immediately upon admission to the previous hospital this patient was given intravenous sodium amyta and placed in the seclusion room, where he stayed for 8 days, treated with chlorpromazine. The report from this hospital describes him as "mute, stuporous, grossly confused, and disoriented in all spheres." It also tells of him striking his head against the wall of the quiet room. His illness was diagnosed as an acute schizophrenic break.

In his initial interview at Oakland he was quiet, cooperative, and pleasant. His answers were clear and relevant. There was some confusion, but no indication of severe tension or depression. It was felt that he was in remission from his psychotic-like episode. His behavior on the ward was satisfactory, and the ataractic drugs were discontinued. Whether his clinical improvement was related to his transfer to another hospital, and particularly his release

to the group, and the few people who ventured them, no matter how psychotic, found themselves under such vigorous attack that they ceased to propound or defend before the group the idea that I would poison them.

In one instance a patient who blamed his strange behavior on his tranquilizing drug said privately to me, "You will see a change in me if you stop it." I told him that I would stop it, not because it was causing his difficulty but because I felt that he could control himself without its help. This action was fully justified by his subsequent behavior on the ward.

Perhaps the frequent complaint that the medicine given to the patient is poison has some truth in it. The truth is that medicine is, on the one hand, a gift of love, a desire to help, from the medical staff. On the other hand, it is an act of hostility, an attempt to quiet, deaden, and silence the patient. The mixed motives in the administration of medicine, the ambivalence of the gift, may be spotted by the acutely sensitive schizophrenic and be described by him as if it were good breast milk which contained poison. Operating, as many of these patients do, at the oral level, the emotional attitudes afforded them by the staff are experienced in oral terms. The word "poison" is one such oral term.

from the quiet room, or was spontaneous is a matter for speculation. He was later transferred to an open ward, where his adjustment continued to be satisfactory.

His history has some significance in relation to the seclusion room. At the age of 3 he had been placed for a time in an orphanage because, as he said, "I was not wanted." When he was 5, his parents were divorced; and when he was 9, he was given in adoption. In the meantime he had been in 11 foster homes. He told me, "They would bring me back one day, and the next day I would go into another foster home. I was unwanted and unhappy and there were cruel experiences." His reaction to the quiet room was an extremely interesting one. "It was boring," he said, "but it didn't bother me," I wondered whether this was one of the various forms of mental defense with which he had met the series of rejections in the long, difficult experience with foster homes and orphanages in his childhood. The quiet room, I observed, often had peculiarly intense significance for patients in whom childhood experience had fostered a strong sense of rejection.

Case Record. (Previous treatment; discontinued on admission and later resumed.)

In this instance, as in the majority of cases in which the ataractic drugs were used on the ward, there was considerable psychomotor activity, with pressure to move and talk. In the previous hospital the patient had been treated with chlorpromazine without improvement. He was described as "excited, restless, and talkative." He had been kept in the quiet room, where he paced the floor constantly and made considerable noise. He shouted threateningly to the corpsmen, "Don't come in here by yourself, I might kill you. You'd better get four people." He was on a number of occasions given sodium amytal "by force."

On his admission to Oakland the chlorpromazine was at first discontinued, but it was resumed on his third day on the ward because his hyperactivity and his parading of status (he was the only officer-patient on the ward at the time) were causing great tension in both patients and staff. The therapeutic community plus ataractic drugs permitted a marginal adjustment, by no means satisfactory, but never necessitating seclusion.

Case Record. (previous treatment; continued on admission.)

The amelioration of aggressive symptoms was sometimes very rapid. This is seen in the case of a patient who had been admitted

to a previous hospital following an acute psychotic episode exhibiting hyperactivity, flight of ideas, preoccupation with delusional religious ideas, and an intense and very noisy desire to spread the gospel. The admission diagnosis was manic-depressive psychotic reaction. The record at the other hospital tells of his jumping up on the bed and preaching loudly. He thereupon was taken to the seclusion room, where he chanted and shouted, defecated on the floor, and pounded on the door and walls. Despite parenteral sodium amyral, oral paraldehyde, and ataractic drugs, he was "violent" when the corpsmen entered the quiet room, tearing his robe to pieces, ripping the blankets, charging the door, and lashing out at the corpsmen. He was finally transferred in restraints to Oakland because of the inability to manage him.

At Oakland the diagnosis was changed to acute schizophrenic reaction, mixed type, and the ataractic drug treatment was continued. On admission he was having auditory hallucinations, carrying on intense conversations with God. He also had the delusion that he was Christ. In the first community meeting that he attended, he crouched before another patient and caressed his feet as if he were anointing them with oil. He began to grow a beard, and he wore his robe as if it were a cloak. The better side of his delusional identity apparently took over and he acted Christ-like as he saw it. None of the violent and uncontrollable behavior seen in the previous hospital occurred, and there was no instance of incontinence.

Case Record. (Previous treatment; continued on admission.)

This patient, a schizophrenic with marked hebephrenic features, had been treated in the previous hospital for several weeks with chlorpromazine, with no effect on his behavior. The hospital report notes inappropriate affect, euphoria, extreme talkativeness, and psychomotor excitement. He was loud and uncooperative, and he caused so much confusion among the patients that he was placed in the quiet room soon after his entrance to that hospital and kept there through most of his stay. In the quiet room he became increasingly noisy, demanding to be let out and beating on the walls and door so violently that the knuckles on his right hand were deeply lacerated. He was quiet only when the corpsmen remained by the door talking to him.

On his admission to Oakland he upset the ward much as in the previous hospital. Chlorpromazine was continued in the same

dose as at the previous hospital (50 mgs 3 times a day), and he showed rapid improvement. Though his thinking continued to be markedly psychotic, his hebephrenic behavior subsided so dramatically that the dose was decreased (25 mgs 3 times a day). It was felt that the improvement was attributable largely to the milieu, but more specifically to the fact that the quiet room was not used on the ward.

Case Record. (Previous treatment; discontinued on admission and later resumed.)

This patient had been admitted to the sick list aboard ship with delusions that he was a "genius," that he was talking with God, and that someone was waiting ashore the ship to kill him. He had auditory hallucinations. In the hospital to which he was first sent, he was treated with chlorpromazine (100 mgs 3 times a day) for a week without any change. He was described as destructive and belligerent, and he was placed in the quiet room several times. Just prior to his transfer to Oakland, he was placed in mechanical restraints.

On his arrival, after my working hours, he was given sodium amytal intramuscularly by the Officer of the Day. When I saw him the next day he exhibited florid hallucinations and delusions. In the interview with me he would rest his head back in the chair with his eyes closed for long periods; at other times he would suddenly start forward and make a noise as if testing me to see whether I would be frightened.

On the ward his behavior was manic in type, with marked flights of ideas. He was a source of serious disturbance because of his attempts to frighten the other patients by constantly making menacing gestures, walking about excitedly, and talking loudly. During the community meetings he would walk away frequently, but would return spontaneously to the group.

I saw him in daily psychotherapy sessions, during which his behavior was markedly different from that which he showed in the meetings or on the ward. He was soft spoken, and admitted that he partly "acted crazy" to frighten the other patients and to prove to himself that he was in control of his mental state. However, it appeared that he could not tolerate the group because he felt rejected by them.

As chlorpromazine had had no effect in the previous hospital, it was initially discontinued. On the third day, however, it was re-

sumed; his behavior had been such that both patients and staff were clearly anxious, afraid, and on edge with him and I felt that, from the point of view of socialization, his motor activity had to be checked. Chlorpromazine was begun in doses of 100 mgs t.i.d.; three days later the dose was increased to 150 mgs and on the following day to 200 mgs. Though his improvement was slight, there was no episode of violence; rather, his aggressiveness came out in playing the role of clown and acting the "crazy man" with mannerisms and verbal productions.

Case Record. (Previous treatment; continued at first and later discontinued.)

The report on this patient from the previous hospital tells of "insolent, demanding, uncooperative, and threatening behavior" on which reserpine, which was given for 13 days, had no appreciable effect.

When admitted to Oakland, he was posturing, gesturing, and occasionally screaming and shouting. This incessant activity continued for approximately 24 hours. The treatment with reserpine was continued on admission. He repeatedly expressed the delusion that it was poisoning him. The medication was discontinued, not because of his delusional fear but because, as in the previous hospital, it was having no discernible effect. He immediately began to improve in his behavior. Had we switched to chlorpromazine and seen this effect, we would no doubt have given the drug credit for miraculous powers.

CHAPTER VI

THE SECLUSION ROOM

During the three months that I had observed the admission ward as Officer of the Day prior to assuming responsibility for it, I learned that the two seclusion rooms on the ward were in almost constant use, night and day, and I often heard patients yelling and pounding on the doors of these small bare rooms over which the words "Quiet Room" were painted. The customary practice was to put patients who were psychotic, delusional and hallucinating, or thought to be seriously suicidal in these rooms immediately upon their admission.¹ Frequently also other patients were placed in the quiet room for various reasons during their stay on the ward. It was the traditional way of coping with the most difficult patients, of punishing (consciously or unconsciously) the most troublesome aggressive patients, and of "meeting the needs" of the more passive patients who asked for isolation.

From my observations of the use of seclusion in dealing with mental patients, I had previously come to the conclusion that the reasons for its use are almost always administrative in nature rather than medical. They can, I believe, be listed as follows:

- (1) Concern for the safety of the other patients and the staff, aroused by the patient's own fear of insanity and loss of control.
- (2) Concern for the patient's own safety, arising from his fear of (or wish for) self-destruction. (Isolation is the traditional technique for the "safekeeping" of suicidal patients, though it is surely open to question whether such a patient is not safer on the ward, where he is constantly with other people.)

1. It was also a common procedure to give disturbed patients intravenous barbiturates upon admission, often in large doses. Since, as a result, they became more unstable physically, more confused and hallucinatory, and consequently less responsive to directions, this often made seclusion seemingly mandatory. I was told that in the past the use of seclusion rooms varied considerably from psychiatrist to psychiatrist but there were no records kept of their use.

(3) Acquiescence to a request (real or implied) from the patient himself, based both on his fear of insanity and on marked dependency needs and regressive tendencies. Acquiescence could be staff participation in patient acting-out and fantasy.

(4) The provision of a retreat or escape for patients who have a fear of their symptoms and the meaning of them (phobias, anxiety, depression, hysterical symptoms) or a fear of external punishment (fantasies and delusions of being poisoned, mutilated, threatened by others with death, et cetera).

(5) Control of the patient who, by his antisocial behavior on the ward, shows contempt for the hospital, the staff, the other patients, and himself. ("Control" here is a euphemism for "punishment"—the setting of limits on a patient's behavior.)

From my observations of the *effects* of isolation on the patients, I am convinced that it is, with rare exceptions,² an antitherapeutic measure. Solitary seclusion in a locked bare room fosters regression and withdrawal in the patient by lowering his self-respect, increasing his sense of stigmatization, and reinforcing

2. The uses of the seclusion room to which I have reference are the conventional uses to which it is customarily put. That its effects need not always be antitherapeutic is pointed out in the following communication to me from Dr. T. F. Main:

"At Northfield Military Hospital, towards the end of 1945, I saw a number of quiet, listless men, without interest in the daily problems of living and working, uneager to speak or play. These were men who had repeatedly lost their friends in battle. The commonest situation was that of a tank commander who had lost one or more tanks from anti-tank shot. Being in the turret, the tank commander was able to get out and save himself when the tank had burst into flames, while his companions, with whom he had fought, slept, and lived, died screaming in the flames inside the tank. Some of these patients had lost several tanks and all had, because of the pressure of the military situation, been allowed no time to mourn, but had had duties demanded of them. Obedient to the military code, they had all carried on until the end of the war, when their apathy and general disinterestedness had led to their being admitted to hospital."

"It was clear that, because of the exigencies of the service, the officers of these men had not been able to countenance the ordinary mourning behavior by which human beings slowly detach their interest from dead friends and direct it once again to the living. As a senior officer I was now able to order these men to pay tribute to their dead comrades by a 3-day period of mourning. In a highly emotional first interview, under hurried conditions of treatment, I verbalized the men's guilt about their own survival, their identification with the dead, and I demanded of them a task that they had hitherto had no inner or outer sanctions to perform—namely a proper tribute to their friends, a concentration of interest

his fears that he is at the mercy of forces within himself and of those who hold the keys. It strengthens delusions and excites hallucinations and often leads to the formation of new ones by depriving the patient of his one tenuous hold on reality—his social contact with other human beings. It encourages bizarre and uncontrolled behavior by confirming his fear that he is "crazy" and by placing him in a situation which invites him to act so. Frequently, too, in neurotic patients, it augments a "need" for isolation as a special privilege, rather than dealing with the need to be needed; in such instances, if the doctor acquiesces to the patient's request to be placed in the seclusion room, he becomes a partner in the patient's acting-out and manipulating.

In my view, then, isolation is in general a sort of license to the secluded patient to abandon efforts at self-control—to intensify and elaborate his psychotic delusions or his neurotic

on them, and honest tears. As senior officer I was able to demand this of them without loss of dignity on their part. I proposed to them that I place them in a single room, darkened, with a Bible at their bedside, and no interruptions other than two meals a day. At the end of 72 hours their time would be up and they would be told to come back onto the ward. The room was not locked at any time. None of these men made any protest at my plan, and they seemed relieved that I took the responsibility for them being permitted otherwise forbidden feelings. I visited these men once a day and, without any tenderness, would simply ask them if they were getting on with the job I had given them, telling them how much time they had left, making it clear to them that they were expected as a soldierly duty to pay proper tribute to their friends.

"At the end of 3 days I ordered the men out and told them that they were now expected to carry out their daily tasks. The whole atmosphere in which this short treatment was conducted had a military flavor. This was necessary because these men had in their time been excellent soldiers and I made little attempt to form a personal relationship with them as they were occupied with relationships of a private nature that I could never share. I confined myself, therefore, to giving them official Army permission to have their own feelings.

"After this 3 days' sanctioned mourning the difference in these patients was striking. Whereas formerly they had not spoken to other soldiers and had carried out their tasks very automatically, now they could speak to the others and, though still rather sad, could work and take part in games and entertainments."

I report this short emergency treatment only to suggest that there may be occasions when seclusion offers a therapeutic opportunity, and that there may be circumstances in which, by tradition, retirement from society into one's private feelings is important. Certain emotional tasks can only be carried out in private—but these tasks are not many; at all events seclusion, so often used antitherapeutically, can occasionally have therapeutic value.

phobias and fears and give free and full rein to his aggressive impulses, his dependency needs and regressive tendencies, his self-destructive fantasies, his antisocial attitudes. It is, in other words, a license to be "crazy," to lose control. As a result, the patient's ward adjustment is not only postponed by his stay in the seclusion room; it is also made infinitely more difficult. He comes out of solitude with memories that are hard to erase and attitudes that hamper his socialization. The experience is one that has driven him inward and backward, rather than forward to improvement and possible recovery. It is destructive to his sense of belonging and facilitates his fantasies of rejection.

Moreover, the effects of isolating patients from the group reach out to the ward as a whole. When a patient is locked in the quiet room, particularly if he is removed from the ward by force, the other patients become extremely apprehensive. It intensifies in some their anxiety over their own sanity and arouses the fear that the same thing might happen to them. Some of the sicker patients misinterpret the screaming in the seclusion room, and fantasy that the isolated patient is being tortured or even killed. Others begin to fear the isolated patient himself, feeling that he must be very dangerous indeed if the doctors consider it necessary to lock him up. The thought that the patient in the next bed is regarded as a suicidal or homicidal risk—as a "maniac"—is a terrifying thought, and greatly increases the fear of the mental hospital, especially at night.³ It also precludes comfortable social relationship with this patient.

Convinced from my observations of the adverse effects of seclusion, I issued instructions to the staff at the beginning of the therapeutic community experiment that we would operate the ward *as if* we did not have quiet rooms. I was always aware, of

3. For example, prior to the establishment of the therapeutic community, it was the practice on the ward to list, with precautions, patients who were: (a) suicidal; (b) homicidal; and (c) escape risks. On one occasion, under unusual circumstances, an officer-patient saw this list on the nurse's desk. He later confided to me that it had terrified him. He had stayed awake almost every night on the ward, in terrible fear, knowing that the patient in the bed on his right had been labeled a homicidal risk and the patient on his left a suicidal risk. Because of this, the officer—who had distinguished himself in combat—said that the experience on the ward had been worse than Korea.

course, that an emergency could arise that would require isolation; but it would only be an exception to the rule. As a matter of fact, no such emergency ever arose; and *not one of the 939 patients who passed through our ward during the 10 months of the experiment was placed in the seclusion room by any member of the admission ward staff.* This suggests, I believe, that under the conditions of the therapeutic community the necessity for using seclusion as a device in dealing with mental patients, for practical purposes, disappears.

Four months after the therapeutic community had been established the head nurse, on her own initiative, converted one of the two quiet rooms on the ward into a music room. The mattress was moved out and a piano moved in. A month later the other quiet room was furnished as an office, and the sign "Quiet Room" over the doors of these two rooms was painted out.

It should be emphasized that I am not advancing the proposition that seclusion rooms should be eliminated from mental hospitals, and certainly controls with which a staff are comfortable such as locks or seclusion rooms are not to be abandoned unless other more effective measures of control are introduced to replace them.

Nor am I proposing anything which is new or original, for there is a natural evolution today toward decreasing use of all forms of restraint in mental hospitals. I am, rather, describing a situation in a given hospital where this action was taken and where it had an observably good effect on the therapeutic process and the socialization of the patients. The expectation that the patient would control himself and the creation on the ward of conditions and atmosphere that fostered self-control were an effective substitute for the quiet room.

SOME SPECIAL PROBLEMS INVOLVED IN THE USE OF THE SECLUSION ROOM

Growth of Dependency Needs and Regressive Tendencies. The admission reports on patients transferred to Oakland from other hospitals note numerous instances of patients urinating and defecating on the quiet room floor. Yet with these same patients on our ward, where isolation was not employed, this type of

behavior seldom occurred and never became a matter of serious community concern over any prolonged period of time. When there was a problem of incontinence, it lasted usually only for a day or two at the most.

This does not, of course, prove any absolute correlation between the use of the quiet room and the incidence of incontinent behavior. It does, however, suggest that dependency needs and regressive tendencies may be predominant factors in a patient's fear of insanity and loss of control, even of his sphincters. It suggests also that seclusion fosters such a patient's loss of control and encourages him to regressive behavior.

In part, the beating on the quiet room door may have a similar significance, for it sometimes represents a recall of childhood's temper tantrums.⁴ But it also has its genesis in other factors of the quiet room experience: the restriction of physical liberty; the loss of equality and fraternity; the intensification of sexual fears, castration fears, homosexual anxiety, and panic; reawakened claustrophobia; bodily disintegration and depersonalization; dissociative thought and speech; and, in a few instances, in extremely aggressive and murderous impulses with associated fears about body integrity and disturbances of the body image.

From a theoretical point of view the hypothesis is suggested that the problem of the seclusion room involves the problem of narcissism. It is clearly observable that megalomanic as well as other delusions emerge strengthened when patients already suf-

4. In an attempt to determine from the patients' histories what their beating on the quiet room walls meant, I arrived at the following highly tentative speculation: namely, those who beat their heads against the bulkhead are different from those who hit the wall with their fists and those who kick the walls. Patients who butt their heads against the wall or the doors seemed more frustrated and self-punitive. They have reached an impasse and can do nothing about it, and their gesture turns their hostility and hatred upon themselves, as if they were "beating their brains out"; those who strike the walls or the bulkheads with their fists have more clearly an outer object of hostility whom they wish to strike, and they are striking the wall instead. Their aggression is more specifically outwardly directed, and their frustration is less in their heads than in their muscles. They are the sort of people who tend to take their hostility out on something or someone else. Those who kick the bulkhead doors or the chairs are more petulant and impulsive, more intolerant of anxiety, and more infantile. They are also more passive. Those who kick behave more in a sort of temper tantrum, not in a self-destructive fashion, but in a socially disruptive fashion.

fering from their symptoms are placed in the seclusion room to bask in their delusions, alone, without any corrective experience to alter them. The hypochondriacal attention to the body, the distortion of the body image, the tearing of pajamas, masturbating, and excreting on the floor of the quiet room are taken as evidence of a regression to an earlier, more narcissistic period. But in all patients, moderately, seriously, or desperately ill, there tends to be a certain immobilization of affect, ideation, and behavior during prolonged periods of self-contemplation and fostered introspection with already distorted perception. (The patient's dependent need meets its counterpart in the staff's need for "dependents" and their own passive-aggressive conflicts.)

Love for others is often rendered impossible by seclusion, with the patient's feeling of rejection. If others do not love, there remains only the self to love. The reciprocal relationship between the love of self and the love of others, between narcissism and object-libido, is highlighted by the quiet room. With the increase in one, the other diminishes. This would account for the regression which we have noted in the quiet room patients.

There is a paradox here in the fact that the very behavior of the patient in the quiet room is often used as *prima facie* evidence to "justify" the use of seclusion. But rationalization is not uncommon in human behavior. When parents, teachers, doctors, courts, or jails provoke a nascent antisocial behavior or rebellion in their "charges," they always take the resultant behavior as evidence that their repressive or punitive attitudes were justified.

Physical Injury in the Seclusion Room. It is not surprising that physical injuries sustained by patients in mental hospitals often occur in the seclusion room, for the behavior of the staff, like that of the patient, frequently regresses in the privacy of the locked room, away from the modifying effect of the presence of the other patients. When a struggle occurs, no matter how cautiously conducted, the sounds emanating from the seclusion room are a pabulum upon which patients may grow all kinds of fantasies about brutality and murderous assault. The effect on the total atmosphere of a ward is massive, and the subsequent distrust of the staff may be out of all proportion to the true events in-

side the seclusion room. If, in addition, the patient shows visible signs of injury when he is returned to the ward, even though he may have injured himself by throwing himself around, the tension and fear are further increased. Staff members too are often injured in the seclusion room when a large and strong patient is forcibly isolated. The injury of a staff member is an exceedingly important event on any mental hospital ward. In general, the seclusion room epitomizes the common conception of "violence" in relationship to the insane.

Once when I was Officer of the Day I saw a patient in a quiet room of one of the wards with a black eye. I asked how it had happened, and the corpsman said, "He refused to come from the other ward to this ward, so four or five corpsmen dragged him here, and while he was being moved, I suppose, someone accidentally gave him a black eye."

On another ward, as Officer of the Day, I found a patient whose face was swollen and whose eye was swollen shut and markedly discolored. On opening the eye, I found that there was a subconjunctival hemorrhage. A glance at the doctor's order book revealed that four days previously the order was written: "Quiet room p.r.n. for agitation after 1630 (Friday) or over weekend." The ward log noted that at 1735 on Friday the patient had become hyperactive while playing basketball and had slapped another patient and hit him with the ball; the corpsmen had then placed him in the quiet room. "Patient went in quiet room on his own after corpsman sprained his ankle while trying to get patient off compound." At 2230 the patient was placed in a wet pack "with much struggling" and at 0130 was taken out of the pack. "In the struggle that ensued he sustained a laceration below the right eye and contusion of the right eye. The patient resisted cold pack quite actively . . ." The account which the patient gave me was that he was playing basketball and the corpsman hit him on the back with his hand. He then hit the corpsman with the basketball and "the corpsman decided to put me in the quiet room. It was about 7 P.M. before the movie party, and then in about two hours five corpsmen came in, three held me down and one kicked me in the head and one kicked me in the ribs [alleged]. This morning when I went to

church I went over the hill. I didn't want any more of this. I was almost killed three times overseas. . . . Mother visited me today and she said, 'The best thing is to forget it, just forget it happened. The doctor said you'd be out soon.' " (The patient was to be transferred to a Veterans Administration hospital the following week.)

My attempts to clarify exactly what had happened by talking with the corpsmen, the patient, and the nurse led only to three conflicting stories.

Requests for the Quiet Room. It should not be overlooked that many patients, particularly neurotic and anxious patients, are relieved to be placed in the quiet room and even request it, for it gives them an opportunity to withdraw from the stresses of reality. But the mere fact that a patient likes the seclusion room is not evidence that it is of benefit for him. Indeed it may be the essence of his neurosis. If he is to get well he must face reality in the social life of the group, rather than withdrawing from it to his own private world. There may be exceptions under other circumstances.

Punitive Aspects of the Seclusion Room. It is quite evident that the quiet room is not infrequently used as a form of punishment. This use is often referred to in professional circles as "control," and its punitive purpose is denied or rationalized. But the ambivalence about it is revealed when the doctor feels compelled to explain to the patient that the quiet room is "not punishment." If so, why is an explanation felt necessary? Perhaps because of guilt feelings. A number of psychiatrists with whom I have discussed the question have readily admitted that they use the quiet room as a punitive device for maintaining discipline on the ward. (The relegation to nurses and corpsmen of authority to use the quiet room except in grave emergencies is, I believe, an abdication by the doctor of both his responsibilities and his authority.)

The patients know, too, that the quiet room is used as punishment, as the following incident indicates: One day the nurse came to my office and told me that a patient had refused to work on the galley and the corpsmen were upset. In refusing, he had said, "I'll go to the quiet room," i.e., punish me. But

the corpsmen told him, "We don't use the quiet room here," and the patient "stormed" into the ward. While the nurse was telling me this, the corpsmen joined us in my office; and as I talked over the situation with them, the nurse went onto the ward and said to the patient, "Look here, everybody has to take his turn at the galley on this ward, and you have to take yours. So come along." The patient responded to her firm but friendly persistence and got onto the job without any further reference to the quiet room.

The patients' awareness of the punitive aspect of the quiet room is also illustrated by the following incident, in which a patient quite obviously attempted to conduct himself in such a way as to bring down upon his head the quiet room "treatment." At the time when this patient was admitted, there was considerable tension on the ward, caused by the presence in the group of a very aggressive and provocative schizophrenic. Using this as his reason, the patient came to me and demanded to be placed in the quiet room so that he could sleep at night. I pointed out to him that if I granted his request, everyone on the ward would want a "private room." He replied, "Well, you shouldn't let one patient keep the whole ward up."

Then for a few days he flouted the ward regulations in every conceivable way. He was frequently found smoking under the bed covers, which was strictly forbidden. He stole matches, which the regulations did not permit the patients to have, and flaunted them in front of the staff; though he readily relinquished them, he took delight in producing another match box at a later moment. When I spoke about the matches to him, he said, "You can't take cigarettes (sic) away from a guy any more than food." (Cigarettes were never denied to patients and were supplied free.) Finally, however, seeing that he was not being successful in provoking punishment, he settled down to facing the situation in which he found himself and made his adjustment to it and ceased to conjure up matches.

The effect of the punitive use of seclusion, like any other step which is punitive, has particular significance in the case of the paranoid patient. As a problem of management, paranoia, whether great or small, presents a particular difficulty. It is this—there is

always a grain of truth in the belief of the paranoiac that people are against him. He then behaves offensively towards the world, partly to defend himself, but partly to provoke the world, to test it, so to speak. Usually the world responds to this offensiveness by ill will, thus, from the patient's point of view, proving that his original suspicion of ill will is justified. Reality having now supported his paranoid ideas, he behaves in a worse fashion; and reciprocally, the world responds with further aggressiveness towards him. This circular situation can grow to the point where the patient is impossibly paranoid and deluded and the world actually persecuting and hostile to him. There is one way out of this situation. As the patient, his ego invaded by paranoid beliefs, cannot do anything to break the vicious circle, the world must do so. It must cease being offensive towards him. In this setting-up of a vicious cycle the use of the seclusion room can play a major part. For not only may it be an aggressive act by the world upon the patient, but it leaves the patient alone, unable to check whether or not his suspicions are in accordance with the real behavior of the people in the world; and out of touch with it, his paranoid beliefs flower freely. When next the seclusion room door is opened, the patient is worse, the environment becomes more aggressive, and the cycle grows. Conversely, once a patient is put in seclusion, the guilt of the staff is dealt with by projection, i.e., by denying their own aggressive, murderous wishes and attributing these to the patient. The subsequent behavior of the patient justifies this projection mechanism; the staff are rid of their guilt; and all the evidence before their eyes is that the patient was "bad" and their action was justified. The need of the staff for a patient to be "bad" can be described as counter-paranoia. In all of this, together with the projection mechanisms, goes, of course, the whole problem of homosexual, sado-masochistic interplay. It is noteworthy that most of this is conducted between patients and staff who belong to the same sex.

Depression and the Suicidal Patient. Suicide is an inherent risk in the practice of psychiatry. Traditional "safeguards" against it in the mental hospital include the use of sedation, restraints, and seclusion. The psychiatrist issues to the staff elaborate formal notes directing them to take "suicidal precautions" in

relation to designated patients and giving them "p.r.n." orders to use drugs and seclusion at their own discretion if necessary in these cases. These methods, I believe, have no therapeutic value and even their efficacy as safeguards is seriously open to question, for mental hospital records are full of instances of suicide. The problem is complicated, of course, by the fact that often one simply cannot tell who is going to try to kill himself. Many a suicide occurs in patients who were not previously considered seriously suicidal. If every potentially suicidal patient were to be secluded under maximum security until the risk is gone, our hospitals would have to be rebuilt with countless solitary confinement cells.

When the whole question of safeguarding the suicidal patient is carefully examined, it is clear that the established procedures are followed, not primarily for the benefit of the patient, but to protect the hospital and staff against criticism and possible legal action for negligence in the event that a suicide occurs. Social attitudes on this problem, as mediated by law, are unenlightened, and the hospital is in a much stronger position if it can point to the fact that the staff were aware of the danger of suicide and had taken all the customary measures to avoid it. The fears created by this situation stand four-square in the way of progress to more therapeutic ways of dealing with the depressed and suicidal patient in the mental hospital, ways that hold out more hope of his recovery and rehabilitation.

The truth which should be recognized is that it is almost impossible to prevent a person really intent on self-destruction from succeeding in it sooner or later. This is just as much a part of the risk of the mental hospital operation as death on the operating table is a risk of surgery. Suicide will occur; and when it occurs the psychiatrist and his staff should bear no guilt for it unless they have been negligent in their therapeutic responsibilities toward their patients. Fear for their own security should not force them into employing backward ways of dealing with the problem.

I believe that, except in the grave emergencies, traditional security measures are not necessary *if staff communication is adequate and if active forms of individual social and group*

therapy are employed to replace them. None of the traditional measures were used in the therapeutic community at Oakland, though over 10 percent of our patients had made bona fide suicidal attempts prior to their admission and the risk was probably present in 25 percent of the total patient sample.

In the course of the 10-month experiment, one patient attempted suicide by swallowing merthiolate while he was being transferred to another ward with a recommendation for electric shock. His stomach was immediately lavaged, and his transfer was continued. Another patient tied a sheet around his neck in a suicidal attempt one morning just before the community meeting; but since this was done in the presence of nurses, corpsmen, and all the other patients on the ward, it could hardly be described as a serious, well-planned attempt. On the other hand, many depressed patients improved noticeably and, while not cured, became manageable and participated in the group life on the ward.

We believed that a patient was safer from his self-destructive impulses on the ward, where other patients were watching him and would talk to him and try to help him, than in the seclusion room, where his lonely brooding would drive him deeper into his sickness. This was a calculated risk that we took in the interests of his ultimate recovery and rehabilitation, which we felt was advanced by the social and environmental forces operative on the ward and endangered by social isolation.

No special "suicidal precautions" were ever issued on any patient. Instead, the suicidal patients were fully and meaningfully discussed with the staff each day.

The practice of writing "suicidal precautions" orders on patients' charts, it seems to me, is sometimes a "buck-passing" device that is not only ineffectual but has some very unfortunate results. If the staff is made to feel responsible for what the psychiatrist himself cannot prevent, their anxiety mounts. The doctor goes home. They are left with the orders, the responsibility, and the patient. They tensely watch him and follow him about, thereby isolating him from the patient community as a specially dangerous case; then, at the least provocation, they medicate and seclude him, primarily to protect or 'cover' themselves.

Under these circumstances, the staff's fear becomes a disruptive element which can seriously interfere with care of the patient. Moreover, this fear communicates itself to the patient. If we expect that he is going to attempt suicide, our expectation is communicated to him by the elaborate precautions we are taking. This only increases the chances that he will do so. On the other hand, the firm expectation that he will not commit suicide can also be communicated to the patient, and can have an effect that will considerably reduce the risk.

None of what I have said here means that there should ever be any indifference to the danger of suicide or that the doctor and his staff should take a fatalistic attitude toward it. No talk of suicide is ever taken lightly. But I do propose a totally different approach to the problem in the therapeutic interests of the patient—an approach which keeps the staff fully informed, but less fearful, and that brings the group to the aid of the patient, rather than plunging him into social isolation. It should not be forgotten that in desperately suicidal patients electric shock may be life-saving and that in some patients so intent on self-destruction it is possible that no force on earth may deter their hand.

USE OF THE QUIET ROOM ON THE ADMISSION WARD BY OFFICERS OF THE DAY

Though we told our patients that quiet rooms were not used on our ward, on five occasions during the early weeks of the experiment, Officers of the Day, who were not members of the admission ward staff but psychiatrists from other wards, placed patients in a quiet room at night without my knowledge. In all these instances the action was taken for routine administrative reasons rather than emergency reasons.

The first time was 6 weeks after the ward began operating as a therapeutic community, and it came to my attention in a curious way. One Wednesday morning a patient came to see me after the meeting to ask for sleeping pills. He told me that he had been unable to sleep since Monday night, when he had had a bad nightmare. "Someone was yelling and getting hurt. I tried to wake up but couldn't. I felt paralyzed. Finally I awoke, afraid. I looked at my watch and it was 3:00 o'clock. I fell asleep in

about an hour." I mentioned this dream to the nurse that afternoon, and she told me that early on Monday morning, the patient in the bed next to this patient had become upset and was afraid that he would lose control and hurt someone. He asked to be placed in the quiet room. The Officer of the Day came to see him at 3:00 A.M., prescribed a sedative, and placed him in the quiet room, where he remained for an hour. After hearing of this, I reviewed my notes on the Monday community meeting and found that it had been devoted to the problem of being a mental patient. I had summarized the discussion in terms of the need which the patients felt to deny certain things and had pointed out that while they had talked a great deal, there seemed to be an idea that talking was dangerous. As time went on, there was much confirmation of this intuitive interpretation, because patients tended to have the feeling, when they first came into the hospital, that if they talked about what was *really* on their minds, they would be put in the quiet room. Incidentally, the patient who had been unable to sleep denied any knowledge that the patient next to him had been away from his bed in the night. However, the insomnia disappeared.

The second incident was likewise not related to me by my staff. The patient in this case had been admitted on the weekend (quiet room incidents usually occurred on weekends) and I had not seen him. He was a manic depressive in a manic phase and had been kept in a seclusion room in a previous hospital. He had been reassured by a corpsman on admission that quiet rooms were not used on this ward. Later in the night, however, the Officer of the Day was called to see him, gave him a barbiturate parenterally, and placed him in the quiet room. (He had been moved back to the ward before I arrived at the hospital.) The Monday morning meeting began with great excitement, with this patient standing up and yelling at me, "Speak, doctor, speak. I'm not afraid of being crazy, I'm not going to hurt you." When I asked him directly if he had been in a quiet room, he became even angrier with me, suspecting subterfuge to win his cooperation, namely, that he had been deceived, for the doctor had secluded him. It was not necessary, of course, to seclude this patient again, and he made a reasonably good recovery, though on one occasion

he provoked a brief fight with another patient. In an individual interview with me after the meeting, he cried almost the entire time. I asked him about the night before; he replied, "How did I feel—how? How do you think I felt? I'm not supposed to be put in a quiet room by anyone who hates me. You know and I know that I'm sane. I won't hurt you. The OD thought I was crazy, he didn't like me. I don't want to go back in the quiet room. You won't put me there, will you?" He then related to me a profound claustrophobia from early life.

The third instance of a patient being put in the quiet room on the admission ward again was not directly brought to my attention. The Officer of the Day transferred an intoxicated patient from his own open ward to our admission ward (in accordance with hospital policy⁵), placing him in a quiet room with verbal instructions that he was to be returned to the open ward at 0700 the next morning (an hour and a half before I would arrive at the hospital).

The fourth patient placed in the quiet room was a hebephrenic schizophrenic who requested immediately on admission that he be given a private room. This was on a Sunday and on Monday morning the staff removed him from the quiet room when I arrived.

It was 5 months before another patient was placed in the quiet room. This patient, who had attempted to commit suicide by cutting his wrists prior to coming to the hospital, was heavily sedated with parenteral sodium amytal by the Officer of the Day on his admission. As a result, he became so groggy that he could not stand. The Officer of the Day then ordered the office furniture removed from the quiet room, had a mattress placed on the floor, and put the patient in there. It would have been sufficient, however, to have had him placed on the ward in a bed with side rails.

5. The policy that patients who got into such difficulties in the hospital or on liberty were sent to the admission ward had an unfavorable effect on our ward and complicated our work needlessly. It tended to create an impression that the admission ward was punishment, and a clear setback (starting all over), and it brought to the new patients an undesirable selection from the wards to which they would go. It would have been better had such patients been sent to locked wards which were not receiving wards or handled on their own wards. But the policy was dictated by the administrative concept (not ours) that our ward's function was "evaluation."

TYPICAL INSTANCES OF CONTROL WITHOUT SECLUSION IN THE THERAPEUTIC COMMUNITY

The following cases are cited to show that the therapeutic community, without using the quiet room, was able to deal with all the types of patients who are ordinarily secluded, and in fact had been secluded, under conventional hospital practices. The evidence on this point is quite impressive cumulatively; but for reasons of space it can be presented only illustratively here. Cases are disguised when necessary to prevent recognition.

Case Record. Nine days before coming to Oakland, this patient (a 22-year-old Marine with 5 years active service) had voluntarily sought hospitalization, saying, "I'm afraid I'll get into serious trouble." He had, indeed, been involved in a number of disciplinary difficulties just prior to this, difficulties which he attributed to a head injury suffered in Korea four years earlier.

At the first hospital to which he was admitted, where he was diagnosed as having an aggressive reaction, he expressed the fear that he would "tear things apart." The note from this hospital states that he was placed on chlorpromazine and in addition was given sodium amytal, phenobarbital, and demerol. Finally he was placed in the quiet room for refusing to take paraldehyde and threatening to "bust the guard's head in." In the quiet room, he tore a large iron pipe loose from the closet and threatened to "bash in" the head of anyone who entered. He was given intravenous sodium pentothal and, after he was asleep, he was placed in a strait jacket. Early the next morning he tore himself out of it, but he was placed in it again just before being transferred to Oakland. When he arrived at Oakland, he was removed from the camisole and told to go onto the ward, but he pleaded, "Put me in a strait jacket. I'm going to tear your ward apart. I just know it. Something terrible is going to happen today." I assured him that nothing would happen, but he warned me, "I'm going to kill somebody."

I told him that he would not do anything of the kind and that, while we would continue his medicine (chlorpromazine) in the same dose, restraints and quiet rooms were not used on this ward.

Just before the first community meeting that he attended he

said to the psychologist on the ward, "I can take this chair and hit you over the head with it, but I control myself." Among the patients individually he established himself as a "violent, powerful" person by talking about his fear that he was going to tear things apart and do something terrible. But it was not until his third community meeting that he confided this fear in the group discussion.

On his third day on the ward he demanded an emergency consultation with me, saying that he still felt that he was going "to tear things up." In a sodium amytal interview (in which he received only $3\frac{3}{4}$ grains of medication) he related an episode from Korean combat in which it had been necessary for him to kill a number of North Koreans as they came over a hill which the Marines were holding. In the middle of this account, he said that there were two lights in the ceiling which he related to the lights used on tanks in Korea "to blind the enemy." In reliving his combat experience, he said, "One of my buddies chickened out on me. I would never chicken out on anybody." But he readily admitted that he was frightened, that he was "scared to death." Actually, he had had murderous feelings toward the buddy who "chickened out" on him; and to his horror, perhaps fulfilling an unconscious wish, the buddy was killed—and himself he said, "My buddy was shot up, and the Koreans came over and butchered him." His first feelings of being unable to control himself and of wanting to do violence or run away, he now told me, had followed upon this experience.

In the interview, in which he was not sleepy, he now turned to his childhood memory of his father, who had often beaten him and had told him that he was "a *chicken* for not fighting." He had both angry and guilty feelings about this. It was not until he had joined the Marines, he said, that he was really able to fight.

Shortly before his present symptoms began he had decided to get married. This involved him in a totally different conflict, on the surface. To prove to himself that he was not really violent, he asked for duty at a remote station, feeling that if he went to the "boondocks" he could really control himself. But instead, he had proved to himself that he was incapable of controlling himself and so unable to get married, "because a crazy man can't get married." He had the feeling, therefore, that he could

not trust himself with those he loved, as if his ambivalent affection was the kiss of death. Despite or because of his dominant feelings of self-distrust—and, by projection, his feeling that he could not trust others—our persistent expression of faith in him was effective.

Had we acquiesced to his request for a quiet room and a strait jacket, we would have further confirmed his fear that he could not be trusted to control himself. Instead we reiterated, "You are not going to do what you fear; we will help you."⁶

The experience on the ward of living and talking with buddies who didn't "chicken out" on him and with a staff who trusted him led him to believe—or to act as if he believed—that he could trust himself and others. So, though he repeatedly reaffirmed that he would do something violent, nothing happened; and the best proof to him of his ability to control himself was the fact that he was doing so. His communications about violence did not frighten the group, who were more impressed by his self-control and his ability to verbalize his feelings than by his dire prophecies.

He maintained that the corpsmen on this ward were his friends and confessed that he had wanted to frighten the staff at the other hospital by letting them know he was crazy; he obviously took considerable delight at their reaction. On our ward he was confronted with a dilemma: either to be really crazy or to control himself; and while he talked the former, he acted the latter. Throughout his stay in the hospital, both on the admission ward and on the closed ward to which he was later transferred, he remained out of the quiet room. Seclusion and drugs had been ineffective. Drugs plus the therapeutic community had been a powerful combination. Perhaps it could have been accomplished without the ataractic drugs, but there was staff anxiety as well as his that was countered by the medication.

Case Record. Another patient who was also afraid that he

6. An interesting sidelight on this case was that one night, when the Officer of the Day made sick call, the patient told him that he was going to "tear things up." The Officer of the Day, to the patient's astonishment and consternation, said, "Go ahead and do it. We'll fix it up again." This type of permissiveness is the direct opposite of the attitude that was constantly maintained on the ward. The Officer of the Day had said, in effect, "Go ahead and lose control. Go crazy." All the rest of the time our staff was telling the patient that he would not go crazy and that he could control himself.

would lose control had a history of violence. Just prior to his hospitalization, in an explosive burst of rage, he had kicked a man in the face, and on another occasion had been found holding his unsheathed bayonet in his hand in the barracks. In the hospital to which he was first admitted, several episodes involving unpredictable, unprovoked explosions of violence occurred. On these occasions he had without warning struck other patients, in one case shattering the other patient's distal radius by striking him with a chair. Immediately after each of these episodes he was deeply remorseful and begged to be put in the quiet room "for a minute or two" so that he could "control" himself. The seclusion room was frequently used. He said that he had always "lived by the sword" and that he was totally unable to control these violent actions.

The hospital report which accompanied him described him as genuinely dangerous to himself and to others, and ominously noted, "All the patients and most of the corpsmen and, I might add, the doctors were frightened of him and never stood up to him."

At this previous hospital he was treated with chlorpromazine. Apparently both he and the situation thereby partially improved. He was transferred to Oakland in restraints and sedated. The diagnosis on which he was admitted was schizophrenic reaction.

On the admission ward his chlorpromazine was discontinued to test whether his self-control was adequate to permit transferring him to an open ward. Even without his medication, he made an excellent adjustment, seemed better able to control himself, and took part in the community meetings. His expressions of aggression gradually diminished. He was transferred to an open ward, where the diagnosis was changed to aggressive reaction, chronic, moderate, improved, and he was then discharged from the service.⁷

Case Record. This patient (a 19-year-old seaman recruit with

7. At the earliest possible age he had quit school to join the Air Force. He was court martialed there for striking a master sergeant, and was given a 5-month sentence and a bad conduct discharge. The next year, however, he joined the Marines, where he again got into difficulty. In evaluating the effects of the therapeutic community, therefore, it must be borne in mind that in this instance other factors may have had a major influence in his improvement—his coming back to the continental United States and the reassuring probability of being separated from the service, where he found himself for a second time in an "impossible" situation.

3 months active duty) had been admitted to a Naval hospital in the United States with a diagnosis of psychotic depressive reaction after he had attempted to hang himself. In this other hospital, strange to say, "no psychotic evidence" was found and "no evidence of depression." The diagnosis was changed to emotional instability reaction, with a notation that he "exhibited nostalgia" and was "a chronic complainer." He was returned to duty, and the next day was readmitted to the hospital for having again attempted suicide by hanging.

His admission orders to the other hospital read: "Seconal grains 1½ h.s., p.r.n. Quiet room p.r.n. Suicidal precautions. Restraints in bed. In quiet room if patient bangs head against wall or attempts to injure himself. Phenobarbital grains 2 by hypo, Chlorpromazine 50 mg. t.i.d." He was admitted to the hospital saying he had no reason to live and wished he was dead. He had spent most of his time there in seclusion.

On admission to our ward he was depressed and showed marked psychomotor retardation. He asked to talk to someone of his own nationality (he was of Latin American background), and in the community meetings the patients vied with each other to be his therapist and to talk to him in Spanish and in English. His suicidal ideas and feelings cleared rapidly though this was not interpreted by us as a cure. His ataractic drug was continued on the ward in the same dosage.

Case Record. The patient was a 20-year-old Marine who had been admitted to a Naval hospital with the diagnosis of schizophrenic reaction, paranoid. He was depressed and withdrawn, had ideas of reference, suicidal ideas, delusions of persecution, auditory hallucinations, and the feeling that he was being hypnotized.

His admission orders to the previous hospital read as follows: "Regular diet, lab, restricted to ward, observe closely for psychotic or disturbed symptomatology." Four days later the underlined entry is made: "Suicidal precautions." Three days after this there is a further entry: "Quiet room. Sodium amytal grains 3 by hypo q. 4 h., p.r.n. Watch very closely." And the next day, "Open ward, sleep in quiet room at night." The final entry, dated 12 days after the order to take suicidal precautions, and immediately before transfer, read: "Discontinue suicidal precautions," and he was then removed from isolation. The note accompanying the

patient to Oakland from the previous hospital explained that he had begun to improve immediately after the decision was made to transfer him. This decision was reached, the note said, "since his rapid recovery was unlikely." The patient received no ataractic drugs either on our ward or at the previous hospital. However, on admission to our ward, he was still delusional and hallucinating.

When I questioned him about his feelings about the quiet room in the previous hospital, he replied at first that it didn't mean "anything" to him, and then said that he had felt safe there because he had the fear that the people on the ward were going to kill him. I did not, however, share the previous hospital's feeling of extreme seriousness about this patient. And in fact he made a rapid recovery, and 2 months after his admission to the hospital he was discharged into his own custody. There are both coincidental and perhaps spontaneous factors which are not fully understood.

Case Record. Another patient, a 22-year-old Marine, had spent the greater part of his previous hospitalization time in the quiet room. I asked him how he had felt about the quiet room experience, and he replied, "Oh, we can talk about Washington and sunshine and buildings."

The corpsman's note from the previous hospital described the patient's behavior there as follows: "He jumped out of bed and started preaching. Was taken to the quiet room. He refused to give up a pair of glasses and we took them in the scuffle. He would not be quiet, so was given Nembutal gr. 3 by force. He saw us watching him and immediately started praying for strength to ward us off, but to no avail (sic). This patient is preaching to the corpsmen, 'Come on and try my God. Give me strength, you devils.' He was violent. When the corpsman enters the quiet room, he doesn't touch a bite of food. For several days he's been fasting. Upsets all the other patients. Thinks he is crazy because he is the Lord [rather than the other way around]. Returned to the ward, but placed in the quiet room again because of his loudness. Continued to preach through the night. Ripped his clothes to pieces; ripped the quiet room blanket; charged the door; lashed out at the corpsman; upon opening the door seems very disturbed. Sodium amytal grains 3 and $\frac{3}{4}$. Defecated on the quiet room floor; says he was ashamed and

wanted to clean it up. Was doing well for a while, then started bouncing on the door, screaming." He was given 8cc's of paraldehyde and transferred to Oakland the same day in restraints.

On admission to Oakland he was overly courteous—for example, saluting me; his answers were clear and relevant, though not appropriate; and he was continually experiencing auditory hallucinations. His behavior became more schizophrenic, with increasing mannerisms and hebephrenic behavior rather than assaultive behavior. The diagnosis was changed from manic depressive reaction, on which he had been admitted, to schizophrenic reaction. On our ward the patient was not incontinent, and he was a refreshing well-behaved though confused member of the group, speaking out uninhibitedly and with sensitive schizophrenic insight in the community meetings.

Case Record. An example of regression in a seriously ill schizophrenic patient occurred when the patient was placed in the quiet room at his own request at another hospital, terrified by the delusion that he had killed his mother. He was given enormous doses of chlorpromazine, which he interpreted as poison. He ate little and frequently urinated on the deck of the quiet room.

On his admission to our ward the "incontinence" ceased. However, his reluctance to eat continued; and in the community meeting other patients told me that he would not eat unless he was fed; so the patients had taken to feeding him. They also observed and told me in the meeting that he often wanted to take food from the others, food which they had had in their mouths, and they were intrigued by this. Perhaps he felt assured that the food the others had tasted was free of poison, or perhaps it was like Mother, putting his food in his mouth after having tasted it during childhood, a feeding technique which in his childhood had occurred. This patient during much of the day would lie on his bed, to which he had regressed in lieu of the seclusion room during the day hours when the patients or the staff were not working with him. On one occasion during the night he asked for sedation and the quiet room, which the staff refused.

Case Record. This patient, an 18-year-old seaman recruit with

sexual fears and phobias, had first been hospitalized with a tentative diagnosis of psychoneurotic anxiety reaction. In the previous hospital, the record shows, he became increasingly confused and disoriented, and was found at the ward door screaming, wanting to go home to his parents. He would rub his abdomen, protrude his tongue, and look at his genitals "to see if my penis is still there." He admitted hearing voices, but refused to tell what they were saying. He had delusions that he was getting electric shocks from the floor. The diagnosis of schizophrenic reaction (mixed) was then established and he was transferred to the Naval Hospital at Oakland.

The corpsman's chart note from the previous hospital tells that the patient would not stay in bed during the quiet hour. He became nervous and tore his sheet up. Several days later he complained that his brain hurt and that everything smelled. He began to throw water on himself, saying, "My generator is running down and my brain smells." He changed his pajamas four times and was then put in the quiet room, where he urinated on the floor. The next day he became more belligerent, so he was given sodium amytal and kept in the quiet room until his transfer to Oakland.

He was admitted to our ward in restraints, and he immediately came into my office asking, "What is that smell?" He thought that he was being poisoned by gas. In his initial interview he complained that there was a tingling around his mouth, and he wanted to know what the smell was. In regard to the voices which he heard, he would only say, "I don't think I can do what they want me to do." When asked what his main difficulty was, he replied, "I am afraid of my mother." I suggested at this point that perhaps his imagination was playing tricks with him. He took a deep breath, sighed, and said, "Yes, that is it." From that point on, he seemed more comfortable and more tractable. He was totally disoriented, with no insight. He was able, however, to accept this sort of explanation that he was sick.

As I walked back to the ward with him after the interview, he pointed to the quiet room door and began to cry. "You're not going to put me in there?" I assured him that I would not. I asked him about his reaction to the quiet room in the previous hospital, and he said that it was "a living hell." He insisted, "This was the beginning of my nervous breakdown." Perhaps

what he meant was that this was confirmation of his breakdown. But confrontation ("Your imagination is playing tricks") was more effective than confirmation, for the former had a rationale which edged its way into the shadows of his mind, and the latter left him alone at the mercies of the irrational. The thought that we did not use the quiet room, he said, gave him hope—"It is just wonderful, too good to be true."

Case Record. The following case is an interesting example of a patient in whom the psychotic diagnosis became apparent only in the quiet room of the hospital from which he was transferred to Oakland. This patient (a 20-year-old Marine with 2 years active duty) had been admitted to the previous hospital on referral by his commanding officer because of acute situational maladjustment. When admitted, he was thought to be only moderately sick; his sickness was described as a character disorder "with predominantly an oral problem," and it was thought that he might soon be returned to duty. However, in the hospital he became disorganized and confused, developed severe anorexia, had to be fed with a spoon, and was trembling and depressed. He was given large doses of chlorpromazine intramuscularly and placed in the quiet room. It was in the quiet room that the first mention is made of a fear that he was going to be killed.

In his admission interview at Oakland, he talked under great pressure, "Please, I don't want to die. Don't make me die. Don't make me do this, Doctor. I made a mistake, Doctor. Don't let those people kill me. I'm afraid I'm going to hurt somebody. They want to kill me on the ward."

Later in the same day he wished to see me in my office, and sat with his legs moving up and down in a quick sort of jumping movement. There was considerable blocking of speech and perseveration. He was totally disoriented and actively hallucinating. The voices were telling him that he was going to die, that if he didn't straighten himself out "something was going to happen."

On the ward he stayed pretty much by himself. He would walk about crying, and would frequently scream, "Don't kill me! I don't want to die!" It was impossible to devote much individual attention to him at this time because of the number of patients on the ward, many of whom were extremely sick. On the third day after his admission he became so excited that

it was necessary to give him an intravenous injection of $7\frac{1}{2}$ grains of sodium amyta.⁸ Following the injection he subsided considerably, and it did not need to be repeated.

For the rest of his stay on the ward, he was quite manageable. Though he continued to use the same words, they no longer seemed to have the same meaning to him or the same impact on him. It is my suspicion that the incapacitating symptoms were interrupted only when, after several days on the ward, reality showed him that maybe after all what he feared would not happen. I suspect, also, that further seclusion in the quiet room, where his terror of the other patients on the ward had first taken hold of him, would have incited the opposite effect.

Case Record. This patient was admitted to a small Naval hospital as soon as his ship docked in the United States. He remained in this hospital for a week and was then transferred to a large nearby hospital with the following note: "The patient was immediately a management problem. He refused orders, pressed for liberty, and on several occasions used the hospital phone in order to contact the doctor or commanding officer who could arrange his liberty. His mood was alternating from facetious laughter to outbursts of anger. In order to retain him on an open ward, he was given chlorpromazine 100 mg. t.i.d. There was an initial beneficial response but he soon deteriorated and was placed in the quiet room because of his attempts to leave the ward."

At the second hospital the psychiatrist's admission orders read as follows: "This patient is probably an acute schizophrenic and may be assaultive. Use quiet room if necessary. Chlorpromazine 50 mg. q.i.d. today, 75 mg. q.i.d. tomorrow, phenobarbital 1 grain t.i.d., seconal grains $1\frac{1}{2}$ h.s., repeat in 4 hours if

8. This was one of only two instances during the therapeutic community experiment when I administered emergency parenteral barbitals. The other time occurred early one morning when I was Officer of the Day. A large, muscular, intoxicated patient on liberty from an open ward in our hospital was found walking the streets and bleeding from a self-inflicted cut on the forearm which was deep but had severed no arteries. He fought the shore patrol and was brought to us in a strait jacket, belligerent and profane, bitter because we would not let him die. The camisole was removed in the examining room. Because he was in a state of extreme excitement, threatening me and refusing to go onto the ward, I gave him 15 grains of sodium amyta intramuscularly. He refused to join the group on the first day but did so on the second day, though he remained silent. By this time he was less sullen but still full of hatred and discouraged and depressed.

necessary. If patient does not take medicine, give intramuscularly and have adequate help (four corpsmen). Call for help if necessary." The ataractic drug was gradually increased over 5 days to 125 mg. q.i.d. The corpsman's chart note on the day the patient was admitted to this second hospital reads: "Was given shot forcibly about 1800. At 2000 patient hit patient [Blank] in the jaw before he could be restrained." The next day he was noted to be friendly and cooperative, and on the day after that he "requested to be put in the quiet room" and went "willingly." He was returned to the ward, but 2 days later the chart reads, "Patient made several attempts to get out of ward. Once he ran to the door and hit it with his head. Was put in the quiet room again this evening. He feared his food was being poisoned. He remained in the quiet room the next day and swung at a corpsman who came in to him. He was returned to the ward but placed back in the quiet room by physical force. This time he refused to eat; refused to take shower. At 2100 while his temperature was being taken, he hit the corpsman. He fell asleep. Awoke and began banging on the door at 2200, not loud bangs though."

After striking the corpsman, the patient was given apomorphine and scopolamine by the doctor, whose instructions now read: "Do not let patient out of quiet room at all except when physically necessary. Use his deck for urination. Three corpsmen at hand when quiet room door is opened." Then, as an afterthought following the doctor's signature, "He is too sullen to cooperate in the social service or psychological workup." The next day, according to the corpsman's note, the patient was "still banging on the door, wanting to get out; said we were putting poisoned gas in him. Also stated he was dying. Now continuing banging on the door."

The patient remained in the seclusion room until he was transferred to the Naval Hospital at Oakland. Here he was no management problem and there was no need for the seclusion room. He was still paranoid about his foods and medication. No medication at all was given to him for 4 days when his behavior was satisfactory, but when he was very anxious and hyperactive he was given reserpine 1 mg. t.i.d., which he readily accepted. He was still afraid that he was going to be killed, but didn't seem unduly disturbed by the idea, and he participated

in the community meetings and showed no tendency to be assaultive.

Case Record. The following case illustrates a type of social problem on the ward that is often "solved" by sending the patient to the quiet room. The behavior of this psychotic patient at the hospital from which he was transferred to Oakland was hardly a model of ward propriety, according to the corpsman's notes. On his admission there, he was "very loud and wanted out," the corpsman notes. "Didn't cooperate at all, caused confusion on the ward, caused other patients to blow his (sic) top. Was put in the quiet room."

The following day, after a brief interval on the ward, he was returned to the quiet room for "persisting in staying up, bothering other patients, talking constantly." And even in the quiet room, he was "most of the time giving us orders on how to get him out." The next day the patient was again put in the quiet room "for provoking other patients." "No complaint," the corpsman observes; "seems happy." On the evening of this day he was returned to the ward, but again taken to the quiet room. And the corpsman now reports: "Very noisy, demanded to be let out, pounded on door, screen, and bulkhead. He was told repeatedly to quiet down, and being in good contact" (which was doubtful from the doctor's notes) "he agreed to, but as soon as corpsman left the room he started making noises again. Was in vain. Sodium amytal. Constantly pounding on the screens and bulkheads with his hands and screaming at people in the street."

When this patient (who always addressed me very obsequiously as "Admiral") was admitted to our ward, he was in restraints and his knuckles were deeply lacerated from pounding on the quiet room door. He was no sooner out of restraints than he started "snooping" around the ward and getting into other patients' bed lockers. This caused considerable indignation. One patient whose bed table had been rifled came and urgently requested that I "lock the fellow up in the quiet room." Others in individual interviews said, in effect, "Either he goes or I do." It was not that they believed this was possible; it was only that saying it was possible—and pleasurable to them. I listened, but made no comment other than, "We don't use the seclusion room." The nurse, however, explained to the outraged patients one by one that the new patient was confused and that it might take him a little

time "to settle down." The next day the patient who had been most indignant and had demanded that the fellow be locked up told him in the community meeting, "This is a good ward, and we have to get along together." Faced with the necessity of living with this patient, the facilitative social forces took over; and the problem was solved without benefit of isolation. The patient himself was never more than a minor annoying problem in management during his stay on our ward.

Case Record. This patient was admitted to Oakland from another hospital within the continental limits of the United States where the diagnosis paranoid schizophrenic reaction had been established because of the delusion that he was God, preoccupation with religious thoughts, excessive megalomaniac ideas, and autistic fantasies.

The corpsman's report on his behavior in the previous hospital begins with the notation: "Unable to sleep since Taps. Every 15 minutes gets up and walks around the other patients' bed-lockers for no reason. Looks in the bedlockers. So it was decided that if the patient continued this, he would be placed in the quiet room." (Admission order: "Quiet room p.r.n.; elixir of Nembutal grains 1½ h.s., p.r.n.") Approximately 10 minutes later the patient got up. It was explained to him that his moving around would disturb other patients so it would be best for him to stay in the quiet room the rest of the night. The patient agreed and was placed in the quiet room."

By the next morning, there was a striking change: he refused to shower and began to eat sparingly; by Taps he was loud and boisterous, lying on his rack and shouting. "Ignored the request of the corpsman to be quiet and was brought to the quiet room without resistance." Now the record notes the first psychotic communications to the corpsman—"Patient says he can read people's minds and 'I am God and the bird of peace.'" He says he is not going to let the corpsman close the quiet room door and that he is going back on the ward. "Patient then took a step out of the quiet room door but the corpsman's arm was blocking the door. When the patient saw he couldn't pass, he changed the subject and began saying that the air conditioner on the ward was a motion picture camera and a tape recorder in disguise. Patient then turned and the door was closed." The next day, it is noted, the patient complained of noise and steam in the water

pipes within the quiet room—"Demanded they be turned off, which is impossible. Patient will not accept explanation of the noise, and continued beating on the door and yelling 'Out.' OOD notified and chlorpromazine 50 mg. intramuscularly was orders. Patient was told he would receive a shot.⁹ After some persuasion, at first consented, then refused. He was then restrained by this corpsman and two others and shot was given by nurse. Patient is now standing at quiet room door, knocking at door and calling out in a moderate voice." This was at 0130. At 0215, "Still in the quiet room and knocking on the door." At 0300, "Now lying down with blankets over his head." At 0900 the next day the order was written to transfer him to the psychiatric treatment center at Oakland. (Whether or not his behavior reached the point where the staff wanted no more of him is not known; but it is interesting how frequently in disturbed patients the referral comes at a point of desperation after seclusion.)

It is clear that the corpsmen had authority to use the quiet room by the doctor's initial p.r.n. (according as circumstances may require) order. But it is equally clear that this method provided no effective solution either of the ward problem or of the patient's problem. In seclusion he took to making considerable noise, and his delusions became increasingly disturbing to him; in fact, his agitation was so accentuated that he had to be tranquilized by medication. In telling him that it would be best for him to stay in the quiet room, what the staff was really saying was that it would be best for them and the other patients for him to be in the quiet room. It turned out, actually, not to be best for him, and probably not best for the other patients either, although under the circumstances it was possibly the "better" of the two alternatives for the staff present on the ward at the time. (The need to tell patients the truth simply and honestly and patiently as a means of winning their cooperation is not unlike the problem of winning cooperation or understanding anywhere.)

It is interesting that the patient in recalling this episode later told me that in the quiet room he developed the idea he could

9. It is an interesting question as to what this delusional patient thought was going to happen to him. The word "shot" should never be used with such disturbed patients in relation to giving an injection. The word "injection" is poor. "Medicine" is satisfactory.

read people's minds. His complaint about the noise coming from the steam pipes was an elaboration of his delusion that there were secret devices on the ward, but here he could fantasy and contemplate the pipes alone by the hour. The corpsman's rational explanation of these sounds was met with disbelief, and did not alter the beating on the door and the yelling to be out. This man had a feeling that something was being shot into his room by way of the steam pipes as well as into himself and that he was powerless. Not infrequently patients in seclusion rooms think that gas is being piped into the room, as if it were a gas chamber. Finally at 3:00 in the morning he pulled the blankets over his head, perhaps to deny the fact that he was in the seclusion room or perhaps to isolate himself even more completely from his reality-shrinking world.

On our ward this patient's behavior was satisfactory, and no ataractic drugs were necessary.



CHAPTER VII

EXAMPLES OF COMMUNITY MEETINGS

THE FIRST WEEK

The first community meeting ever held on the ward dealt with minor annoyances arising out of the hospital situation. The opening communication, from a patient who had been in the service for a long time, was the complaint that there was no coffee hour and that no coffee could be had except at odd moments "when the staff gets it." This theme was taken up rather energetically by the group. I made no comment but listened carefully; and after a short silence a patient, assuming the role of the spokesman for the group, came to the defense of the staff: "Let's not get it wrong; we think the nurses and corpsmen are trying to do things for us."¹ But again there were comments about the availability of coffee in other parts of the service, on shore and afloat. I interrupted with the question, "Could not this mean something else? Could it not be referring to a more basic conflict?" In phrasing this question-interpretation, I was thinking of frustration and deprivation of liberty in the hospital; but to my surprise a chief answered, "If you mean whiskey, I think they are separate."

1. The majority of quotations reported directly from community meetings are taken from the extensive notes which I made immediately after the meetings were held and all the significant communications had been jointly reviewed. While there were available tape recordings and sound motion pictures (for some groups) and extensive dictated notes, by far the most valuable and useful records, I found, were those which I myself typed or wrote in long hand. The advantage of the notes as against the precise accuracy of the recorded words lay in the interpretive comments, writing of immediate personal associations and reactions, nonverbal communications, gestures, and social events which elaborated these daily notes and diaries. When it came time to transcribe the tapes, already some of the memories and the spontaneous feelings had been lost. As against the mountain of recorded data from transcribed material there was in effect an immediate abstract which we found most useful. While this involved a conscious selection of material, so does any other way. The comparison of notes with tape recordings, as well as many years

The group then turned to complaints about not being able to smoke during quiet hour and about too much noise on the ward at night. Some patients also objected to the quiet hour, "Why do we have it anyway?" Others said they liked the quiet hour.

One patient then aired his grievance against the corpswave in the outer office on the ward who wouldn't let a friend of his, who had arrived during the last ten minutes of the visiting hour, stay beyond the closing time. He said, "I've never hit a woman before, but she would be the first," and he went on to relate similar trouble with women in the service. He said "would be," not "will be." No threat was involved, I thought. I asked, "Was there an earlier time?" He replied, "No." Then, coming more directly to the point, I said, "Did your mother treat you this way?" He replied, "Yes, until I told her I was going my own way, and she said I wasn't. When I was sixteen, I pushed her aside, and we've gotten along fine since."

This subject was carried no further. There were further complaints about the corpsmen monitoring the patients' telephone calls and supervising their visiting hours, and I then concluded the hour with summarizing comments on the annoyances that attend being in the hospital.²

2. It was my custom to conclude each community meeting with a 3- to 5-minute summary. I chose the theme which seemed to weave most constantly through the hour and pointed out its development, the precise words used, and its ego level, meaning or interpretation. This will be discussed in a later chapter. I illustrated the points in my summary of the meeting by quoting significant comments made during the hour and attributing these comments by name to the patients who had made them. This assured the patients that, though I might be silent, I was listening all the time. It also gave a feeling of status to the patients who talked, and the pleasurable sensation of hearing their own words spoken back to them in a calm and quiet voice with the obvious inference that what they had said was meaningful. It gave a sense of structure to the group meeting which on the surface often sounded chaotic.

of experience recording interviews immediately after the event and the constant corrective experiences of reviewing the communications in the staff meetings, leads me to believe that the quotations used in this book have a high degree of reliability and in most instances are exact. In addition it should never be forgotten that the introduction of recording devices affects both patients and staff and introduces a significant variable whose effect is exceedingly difficult to evaluate. A further complication rests in the fact that many comments in a large group are hardly decipherable from tapes.

In the staff meeting following this first hour, I suggested that there might be some validity to the patients' complaint about coffee, which had occupied so large a part in their discussion, and I proposed having the corpsmen get an extra pot of coffee with the chow so that there could be a definite coffee hour in the morning. The staff went along with this proposal, but their annoyance at gratifying the patients' "demands" was revealed in the comment of a nurse, "Now it is coffee; the next time it will be milk."

Thus in the first community meeting the patients had had an opportunity to air their complaints. Those which were realistic could be satisfied, although not directly in the meeting.

The following day the theme of the community meeting had to do with a deep anxiety relating to fears about psychiatry and the disadvantage of the patient when pitted against the authority of the psychiatrist. I took my seat in a chair by the end of a bed, the position which I occupied in all community meetings that followed. The patients gathered their chairs in a circle about me.³ However, the staff was having some difficulty in adjusting to the group situation. The charge nurse sat at a card table writing notes, quite far away from the group. I asked her to come over and sit with the group, and she replied that she had work to do. She continued writing and later on walked out of the group. I felt somewhat anxious over this; and I was to experience this very slight anxiety every time that a patient or staff member walked from a meeting.

After the meeting had begun, a social worker entered late with a cup of coffee in his hand. I felt that this action was directly related to the last hour and was a hostile gesture towards the group, but I said nothing about it in the meeting.⁴ The patients were now more clearly talking about me, though indirectly. The first communication was: "I feel the patient" (not phrased as himself, but as the more general category or class,

3. Even in this first series of meetings we became aware of the fact that the seating arrangement had great significance. It was not yet clear what the meaning of any specific chair was, but it was clear that there was a nonverbal communication in the seating. Those who sat behind me, those who sat across from me, those who sat in chairs away from each other or clustered in groups—in each case there was obviously a social communication.

which would include the group) "is at a disadvantage with the doctor—the boards of doctors won't pay any attention to us when we appeal or rebut."

They now were talking about what would happen to them at the end of their hospital stay, when they appeared before a medical or survey board—an administrative problem which heretofore had been the major topic of discussion on this ward. The social worker had held meetings with the patients to explain to them the operation of the boards, the nature of separation, and their compensation rights under the laws. Now the test was being presented to me. Finally a patient turned to me directly and said, "Don't you think we're at a disadvantage?" I replied without a moment's hesitation, "Yes, you are at a disadvantage *administratively*."

The immediate answer was honest and reassuring. The emphasis here upon the word "administratively" implied that *therapeutically* it was different and placed the comment in a new perspective. Thus this short, simple answer was important, I felt, in establishing an idea of what might be characterized as a "benevolent authority." There was a long silence after this, and so I expanded on my answer to "justify" the administrative responsibility, saying, in a matter-of-fact way, that when patients come to boards some want more than they should get and some are afraid to ask for what is due them and that someone or some group must be administratively in charge whether it is aboard ship or in the hospital, the doctor or the officer. Immedi-

4. In the following staff meeting he was questioned as to why he had done this. He attributed his conduct to the fact that, when he had reported in the morning, he found that his captain had, without consulting him, arranged an interview for him which had disturbed his entire morning schedule. He thought to himself, "If I'm going to be pushed around I'll make them uncomfortable too." As he walked in with the cup of coffee, he told us, he had the feeling, "I'm going to drop it." Then he thought of setting it on the floor, but he said to himself, "To hell with it," and sat drinking coffee in front of the group. "But," he said, "I didn't enjoy it." He wondered why the patients didn't say anything about it, and he thought perhaps that they hadn't wanted to "embarrass" him. But, since there was an element of defiance of the group in his behavior, the patients may perhaps have feared that if they brought it up there would be some retaliation: "He will report me; he will foul me up; he will do something since he does not show consideration."

This type of immediate analysis was sufficiently instructive to the staff that such behavior rarely occurred.

ately, a patient said, "I am never afraid of any officer or any board."

The patients obviously felt more comfortable with me now, and a direct reference to me followed: "The patient is at a disadvantage because you know all about us, and we don't know anything about you." This was the first clue that the reference to the "patient" and the "doctor" was not simply the military or social custom of speaking in the third person, but had something to do with me personally. I replied, "Are you curious?" And he said, "No, not especially." But the "not especially" was a signal that he was indeed curious but reluctant or afraid to say so, but I said nothing.

The patients then turned the discussion to the psychological tests which were required of all patients admitted to the hospital.⁵ It now became evident that these tests were thought of as an extension of me, for several patients spoke of "the questions you asked." The patients felt that the tests were unfair, and some of them derisively quoted questions from them: "Do you believe in spanking your child?" and "Do you have a tendency to suicide?" After the word "suicide" there was considerable animation in the group, with a number of the patients expressing their objections to the tests and their sense of being at a disadvantage. "Someone has the upper hand," they concluded.

This led into a discussion of the closed ward: "Why am I locked up here when I came from an open ward at another hospital?" A patient turned to me and asked, "How would you feel?" I made no reply to this question, for I did not know how I would feel if I were locked up. Moreover, the point was not how I would feel, but how they felt; it would have been a mistake to say, "I know how you feel." I realized too that, since I believed that many or most of the patients could be cared for on an unlocked ward, any answer that I might make would have identified my feelings too strongly with the group. (It is my belief that there will in time be more open hospitals for mental patients.)

5. In the beginning of the therapeutic community program, as in the past, it was a routine that all psychiatric patients be given a battery of psychological tests, the results of which were not discussed with the patient. This "routine order" was soon changed in consultation with the Chief of Service and the Chief of Psychology so that tests were administered only on special requests when indicated.

My silence, it seemed, implied to them strength; they interpreted it as meaning that I was "strong" and would answer questions which I thought I should answer and would remain silent if I thought I should not answer. The decision about which questions to answer was at first intuitive, but gradually I learned to recognize this type of question as a seductive one; and since the patients clearly regarded me on an administrative level as a part of the command which considered it necessary to lock them up, for me to give them any inkling that I was not in accord with the hospital policy would have permitted them to use the meetings for manipulative purposes. My silence was noncommittal and, while it might have been interpreted as rejection and provoking of anxiety, it was evident to me from this point on that sometimes this was the essential role which the leader must take.

In this instance my silence was rewarded by a very meaningful comment from a schizophrenic patient. He said, looking at the group, "You live here as being uprooted, and then you begin to die inside." Then turning to me, he added, "You give me a chance to let out steam. . . . the tree removed as a sapling takes root again, but can be left to grow, and the roots that are broken off—it begins to die within."

I asked, "Can you be more specific?" and then, giving him a clue, I asked, "About yourself." "Yes," he replied, "my wife is everything my mother was. I don't know how the rest feel, but you ask me and I tell you."

Here he had swiftly communicated a major feature of his psychosis: his identification of wife and mother with the sense of being uprooted and his fear of mutilation and death as expressed in the metaphor of the tree with its roots broken. I concluded the meeting with summarizing comments, using their own words where possible, covering the patients' sense of being at a disadvantage, their feeling of dissatisfaction with mass treatment, their dislike of the psychological tests, and their anxiety about how the doctor would interpret their answers to the questions.

In the next day's community meeting, a patient introduced a subject which clearly had meaning for the group as a whole, when he said: "I don't get answers from the doctors; they put

me off, and they don't see me." There would have been no point here in coming to the defense of doctors because it was obvious that many of the patients had actually in the past been put off by doctors, that they had not been seen. What would be important to the group would be their own observation that on this ward they would be seen, that they would not be put off; and this was a matter to be demonstrated, rather than verbalized. Some speculation was then expressed about the community meetings themselves. One patient said, "I have sized up these meetings. They are to find out how you can improve the hospital." Another patient said, "They are to draw us out."

In this meeting, as in others, the patients protested against the hospital's routine practice of sending a letter to the next of kin, notifying them that the patient was on the psychiatric service. I attempted to explain that this was an administrative decision on the command level (i.e., while I accepted it I was not responsible for it). But one schizophrenic patient refused to accept this, and by a curious paranoid distortion he told the group that I had informed him that his letter would say, "Suicidal tendencies." I denied this, pointing out that I did not write the letters and had no idea what specifically would be said in them; but he replied, "There isn't anyone else here who looks like you," to which I immediately agreed. But the group as a whole accepted my explanation in a semi-humorous vein, as if accepting the inevitable. Again I was drawn into the administrative side of this problem by a patient asking, "Can't we have some say about the letters?" To this I replied immediately, "No, this is a routine." It seemed to me that the question required a direct answer, and for me to have evaded it by saying, "Talk to the Captain about it" or "Talk to someone else about it," would not have permitted them to handle their feelings about it effectively.

A patient said that he was having domestic difficulty and his wife would use the letter as "ammunition." Another said, "I have no next of kin," and when I replied that everyone has next of kin, he said, "Then it is my mother-in-law, and she will say 'I told you so.'" At this the entire group burst into laughter. The tension was broken. Then another patient, caricaturing the letter, said, "It will read, 'Your son is in the nut-house.'" There

was no laughter at this; only silence. Then a patient said, "Well?" and the group burst into a convulsive laughter, which enabled them to accept in caricature what they all felt. But it was not really a humorous situation. Another patient said, "I am sorry I listed my mother—she is old. I should have said brother."⁶

The following meeting began with hostile complaints about food by a patient who was a cook in the service.⁷ But the group did not rally to his side, and only his closest buddy "went along" with the complaint—a clear indication that this topic was not group-approved.

Then a schizophrenic patient just admitted said that he had some strange thoughts he wanted to talk about but was reluctant to do so in front of the group. A sergeant next to him gently urged him to talk by saying, "We are all in the same boat. No

6. After we had adequate evidence, it was presented to the Chief of Service and thereafter in any case where a next-of-kin letter seemed administratively unnecessary or therapeutically contraindicated at this stage of their hospitalization, letters were not sent. The routine became modified and was no longer automatic. While it looks as if the early groups were dealing with gripes, the meetings did not sound that way. The patients were deeply concerned about reality problems which immediately were aired once the lid was raised and they were "given a voice," though not a vote. As time went on "practical matters" of these sorts became rare group topics.

In this meeting, however, my own ambivalent feelings about the letters and my intention of changing the routine policy if possible was detected by the schizophrenic patient. His reply in fact accuses me of deceitful action. It was probably an error for me to deny his paranoid accusation so literally rather than deal with his feelings. Fortunately the group "rescued" me and the patient from this error by way of a "comedy of error" association: ammunitions; no kin, mother-in-law, wrong kin, and nut-house.

7. This man and his buddy were the oldest patients on the ward; both of them had been admitted for attempted suicide with firearms and both were being sent to another military hospital for treatment on the East Coast, where their families lived. One of them asked, "Will it do any good to tell the Admiral?" But their hostility had little to do with the group. It had to do with their imminent transfer to Philadelphia and with the fact that, immediately preceding the community meeting, a sick call had been held with a regular Naval officer who was in the position of command superior to me in the hospital. The questions which he asked at sick call were administrative questions which it had been my policy on the ward to reserve strictly for personal interview in my office. For example, as we came to one of the two patients who were being transferred, he asked, "What are your plans for him? Is there any disciplinary status? Is he going to Philadelphia 1A?" (meaning in restraints and sedated), and, "Oh, so you're Smith!"

one will laugh at you." The first patient said, "It will sound crazy." Another patient told him, "I have been in group meetings before and it helps to talk. You get help from each other. We all feel alike." This led into a discussion of self-consciousness and of fear about talking and revealing intimate details of one's life. When the word "crazy" was used again, a very sick schizophrenic patient burst into laughter and walked from the group to the water fountain. On his return I asked him why he had left, and he said, "I felt that all the eyes were on me." (He had seated himself directly behind me, where the eyes would be focused, "so as not to obstruct anybody's view.") I asked him if he had ever felt self-conscious before, and he said that when he was 13 years old he had edema of the eyes and people laughed at him. I suggested that perhaps he felt the same way now, and his voice quavered as he reflected, "I feel self-conscious." A nurse then said, "I feel stage fright whenever I give a talk. Everybody feels the same way." A sergeant added, "I felt that way in the ring even, when I was knocked down. I felt frozen, but not afraid, but even Joe Louis feels that way."

Then finally the schizophrenic patient who had had the strange thoughts overcame his fear of sounding crazy and talked about the supernatural; he had strange powers, he said, that he feared had caused the death of many people. The general tone of the group developed along the lines that superstitions were often stronger than logic, that feelings and irrational processes are more potent than rational objectivity. At the end of the meeting a colored patient said, "In Japan they worship Buddha because they are not enlightened about Christianity," but another patient commented, "They feel the same about it the other way around there," which was an expression of tolerance for strange beliefs.

In the staff meetings, as the content of the patients' communications was discussed, it was now becoming obvious that one of the main functions of the staff meeting was to relieve the anxiety of the staff members by giving them the feeling that each community meeting had structure and meaning—that it was possible to follow threads through it and to relate what was said to what was known or inferred about the patients.

By now the staff was beginning to feel competent, and already a ward culture was beginning to take shape.

THE WINNING-OVER OF AN UNCOOPERATIVE PATIENT

One series of meetings held in the early days of the therapeutic community had an impressive effect on the staff, not only because it brought into the open the patients' feelings about restraint, maltreatment, and the use of the seclusion room, but because it memorably demonstrated how the patients themselves, with a minimum of participation by the staff, dealt with and won over to the group a patient who at first refused to cooperate.

This patient—Gordon—was an 18-year-old Marine private who had been admitted to the ward from a Marine station in Japan with a diagnosis of schizophrenic reaction. When I saw him in his admission interview, he was sullen, hostile, and resentful, but not depressed, and it was my impression that the correct diagnosis was severe passive-aggressive reaction (a character disorder).

He was an only child, whose father had deserted the mother when the boy was 3 years old: "Father left me—left my mother," he told me. He denied any memory of his father, but his mother had constantly described him as a shiftless drunkard, and had told the boy before he was 10 years old of reading in a newspaper that his father had tried to commit suicide. Following the father's desertion, the boy had lived with a grandmother until he was 10, at which time he went to live with his mother, who had remarried when he was 5. It was always incomprehensible to him that he had not been reunited with her earlier. The mother, from whom he received little affection, was an alcoholic, and the stepfather forced upon the boy the role of baby-sitter, for mother, fostering in him the feeling that he was "the only one who could control her." When he was 17, he joined the Marines to "escape" his mother. She signed the waiver of age, saying to him, "Good riddance."

In the service, he rapidly found himself in repeated disciplinary trouble, beginning with a brig sentence received for going AWOL on his third day in boot camp. His experience in the brig confirmed his sense of rejection. He described the people who ran it as "wise guys and inhuman." When he was discharged from it, he said, they called him in and beat him up "as a lesson

not to come back again." ("I got the - - - kicked out of me.") There were many threats and "they said they would shoot me if I didn't say 'Sir.' "

Throughout his following months in the service, his intense hostility to authority figures had led to repeated difficulties with his superiors. It was a serious grievance to him that he had never received an advancement in rate.

The first community meeting which Gordon attended began with a long silence. Another new patient—Harrison—had seated himself apart from the group and I invited him to come and join us. He accepted the invitation angrily, bouncing his chair on the deck as he came, and sat next to Gordon, with whom he began a hushed two-way conversation, excluding the rest of us. I asked Harrison what he was talking about, and he said he was complaining about the ward.

Gordon told us, "His trouble is insomnia," and Harrison added, "The night lights are too bright. They keep me awake." This was followed by a long silence; then a patient who had been on the ward for eight days asked, "How about explaining the community meetings to the new patients?" I invited him to do this, and he described them as an opportunity for the patients to talk about whatever they wanted to and to get help. Gordon sat in a chair drawn out from the circle, clearly the center of the stage. He was the sullen picture of the "angry man." The patient who had explained the community meetings remarked, after a period of silence, "We have to cooperate." Gordon angrily rejected this. The doctor had told him, he explained, that he was not going to have any leave on this ward and wasn't going to the open ward; and since his demands had not been met on the first day of his hospitalization, he declared, "I won't cooperate with anybody. The doctor has my record and knows what's wrong with me."

A patient who had made a number of penetrating interpretations in previous meetings warned him, "You'll never get out of here if you adopt that attitude," but the threatening aspect of this communication was softened by others, who said, "You need to cooperate," and "There's a need for understanding." At this point a patient who was delusional and actively hallucinating

said, "It's a family," Gordon sneered, "Like mother and father and children."

Now another patient gave a testimonial, "I have been helped by the group discussions." Gordon received this in angry silence. Then a patient named Jamieson, who had been evacuated to the United States from Japan with Gordon, volunteered an explanation: "*I'll tell you why Gordon is angry and feels the way he does.* We came from an open ward in Japan, and then we were put in a locked ward in Hospital X and changed from class 1B to 1A [placed in physical restraints and given sedation], and something happened in the quiet room in Hospital X."

At this point Gordon snarled and took up the story with feeling, telling how he had been "beaten up" in the quiet room for refusing to lie down in his rack at night. "They took me there by force," he said, "and outside the door a corpsman said, 'Is the nurse there?' and another corpsman said, 'No.' Then a third one said, 'Well, we can have our fun.'" (Homosexual implications or fears in the use of the seclusion room are not uncommon.)

Gordon said that his head was beaten against the deck, that he was punched and kneed and slugged, and that he screamed so loud it could be heard all over the hospital. In telling this, he became so tense and anxious that Jamieson, perhaps as an indication of identification and support, said, "I was in the quiet room too, and I wanted to help him, but I was so groggy from five injections of amytal that I couldn't even stand up. I slipped out of restraints five times and there are buckle marks on my arms and legs, and I can show them to you." But no one asked to see them.

Then Jamieson, in mounting excitement, described how it felt to be in restraints; and his description was tense and terrifying. He concluded by turning to me and asking, "How would you feel about being in restraints?" I was silent. "No answer?" he queried, and I replied, "No." There was silence, almost surprise in the group, for I had failed to become a partisan though my empathy with the patient must have been obviously revealed in numerous nonverbal ways. I think it would have been impossible to deceive them and a mask would have been inappro-

priate. Perhaps my attentiveness itself was enough to indicate that I was "going along with him." But, by maintaining the doctor status and not becoming involved with him, I had also forced him to face his anger. Gordon turned to Jamieson and said, "How did you feel when the doctor didn't answer?"

And now we were on to something which could be used. I repeated the question and pointed out, "Perhaps it is more important to know how you feel."

But before he had a chance to answer, a patient who had been through previous community meetings said, "When the doctor didn't answer me before he found a lot more out, what I had in my mind." But Gordon only expressed his feelings of indignation at being on the locked ward.

A patient who had never previously spoken, though he had been on the ward for a week, said, "I felt (sic) that way." Others agreed.

The patient whom I was seeing daily in individual therapy said, "This isn't a locked ward, this is an admission ward."

But the realist Gordon wouldn't let him get away with that. "What about those windows and that door?" he asked. Then, possibly as a provocation to us, he asserted, "It will take five men to put me in the quiet room."

"We don't use the quiet room here," I told him.

"I heard that the nurse sitting over there (points) had put a patient in the quiet room by herself," he replied. But this was obviously intended in a humorous sense.

Another patient, picking up the humorous implications, said, "I'll bet Miss Austin could do it by herself."

I thought now that perhaps the discussion could be turned to some of the factors in the genesis of Jamieson's intense feelings about restraint. So I asked him whether he had ever been restrained as a child.

"No," he said, "nothing in childhood like that." And then, almost preferring to go back and talk about the alleged mistreatment in the service, he talked more about his quiet room stay, and particularly about the fact that he was refused permission to attend church, "though the Protestants did."

"Here you can unless the doctors think you can't control

yourself," another patient said.

Now the theme of self-control had been raised, and I interpreted by saying how important it is to control oneself, for there are frustrations and intense feelings in being restrained by others, even if the restraint is not physical and even if one is not being hurt. But, having failed to hit pay dirt in the use of the word restraint, which Jamieson interpreted as physical restraint, I attempted again to pursue the return to his childhood: "I wonder if there was not something like that in your childhood."

"Yes, when I was 14 I came home one day to find detectives and the fire department and the police," he said. There had been an explosion, and the house had burned down. Someone told him that his parents were in the hospital and that he was going to be taken there to see them; but, as it turned out, he was taken not to the hospital but to the morgue, where he was shown the charred unrecognizable bodies of his parents.

The group were so moved by this experience that several of them broke into tears, and one said, "I have never had anything so terrible happen to me. It helps me to know about it." There was almost a rush of sympathetic and empathic communications to him.

At this point Gordon turned his chair to face me, the snarl gone, and said, "Well, sir, the Marines" (not the doctors, not the Navy) "never did nothing for me. I was up for Pfc. and not given a small stripe, which means a lot in the Marines." Other Marines in the group took exception to this; one was a sergeant and one a corporal, but he maintained that this one stripe meant a lot. The discussion ended on a difference of opinion, but without any strong feelings about it, and while I felt that obviously to the corporal and the sergeant the stripes meant a great deal, what they were saying to him in effect was simply, "Don't feel bad." So, after all, the Marines were doing something for him.

The meeting the following day was influenced by the presence of our first observers from outside the hospital.⁸ The patients

8. Both were in uniform; one was a medical officer from another psychiatric ward in the hospital, and the other was a psychologist on training duty. Visitors could not, of course, be barred entirely, both because of their value in bringing instructive

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were affected by the moving excitement of yesterday's discussion and I was aware of a conscious wish for this meeting to be an equally interesting one for our distinguished visitors. But in my desire for the patients to perform well for them, I committed two errors, which were not repeated again. The first error was my beginning the meeting by saying, "Is it all right for Dr. Brown and Dr. Bill to visit the meeting?" Several patients said, "Yes," but, as one of the corpsmen remarked later, "What the hell else could they say?" It was an unrealistic request on my part, unrealistic in that it did not take full cognizance of the authoritative role that I held in the patients' eyes as officer as well as doctor. Also, in some measure, I was perhaps exploiting their momentary good will. I should rather have simply stated that such-and-such people were visiting the meeting today and told clearly who they were and why they had come. (It was only later, much later, that we were able to understand the full impact of visitors, though the extreme importance of complete honesty in com-

observations to the staff and because of the educational value of our experiment to them (which we felt was one of the missions of our job). Visitors affected my feelings and actions. There was no doubt that whenever visitors were present the groups behaved in a somewhat different fashion. They were extremely sensitive in divining the attitudes and anxieties of the visitors. They were less affected by Naval officers in uniform, particularly if they were psychiatrists, than by any other type of visitor. When these visitors were of high rank and manifested little obvious anxiety, the therapeutic process of patients helping each other tended to increase, partly perhaps because of the patients' desire to show themselves in a favorable light and partly from a desire to show, or perhaps even deny, the mental hospital aspects of the ward. For one visitor who was clearly motivated by scopophilia and the desire for a "thrill," they behaved in a very angry antitherapeutic fashion. For several civilian psychoanalysts, they behaved with amazing sophistication. Visitors who came for several meetings had a decreasing impact on the group and a greatly increased awareness of what was happening in the group. (Because of the rapid turnover in the patient sample, it was almost impossible for a person visiting the ward only once to go away with a clear idea of what was happening.) On the occasion when Fleet Admiral Chester W. Nimitz came (accompanied by the Commanding Officer of the hospital, Admiral J. Q. Owsley), the group behaved in an unprecedented way. It was as if they were trying to "frighten the brass"; and they did put on a show, talking about suicide and razor blades and hostility to the medical corps, and about being crazy, and about wanting to kill or hurt other people in the group. In a sense they caricatured the role of the psychiatric patient for a world-famous nonmedical visitor, who, however, was comfortable, poised and friendly in the group. He seemed to clearly understand what was going on. In the next day's group there was a manifest amazement and gratitude and appreciation that Admiral Nimitz had seen fit to visit them and talk with them.

munication about visitors became evident early. Failure to identify visitors, we found, led to fantasies about snoopers and outside authorities, and to a feeling among the patients that they were performing for other people, rather than primarily for themselves.)

The meeting began with a long period of silence, which was finally broken by complaints about leaky faucets and cockroaches in the head. In the discussion that followed, a patient who had a very definite sibling problem said, "Cockroaches don't breed like humans. Every night we have new cockroaches." I suggested, "Sometimes like younger brothers and sisters coming along. Human beings breed all right, but not so quickly; perhaps, though, this is the topic which is of much more importance than the cockroaches." It had an impact.

A number of other complaints were made, and then Jamieson asked, "Why can't we have knives and forks?" One patient replied, "If they give you a knife, I'll leave." Since there was no probability of us giving them knives and no possibility of their leaving, this was met with laughter and a relief of tension by the patients and silence by me. Finally, towards the end of the meeting, Jamieson commented that what he didn't like was the corpsmen. He thought for a while and added, "Yet, it was good that one of the corpsmen in Japan would do the shopping for the patients." Another patient replied, "He made money on it."

My second error was to call on a silent patient by name as a school teacher calls on a pupil to perform. I should have waited for we already knew that this device was largely sterile.

Gordon had taken no part in the discussion at this meeting. For him, I felt, the hour was a necessary period of restitution after yesterday's meeting. At first he sat reading a magazine. Since it was clear to me that we could not permit a patient to withdraw from the meeting by this behavior, any more than by walking away, I asked him why he was reading instead of joining the group. After a moment or so he laid the magazine down, saying, "It's hard to talk." I let is go at that, for the magazine then became a therapeutic gesture about his difficulty and sensitiveness about talking, rather than a symbol of contempt for

the meeting, defiance and withdrawal from it.

In the Thursday meeting the discussion revolved around the themes, "When does one talk and when does one not talk? (in community meetings). What is at stake in talking?" This theme had its genesis, I believe, in the magazine episode with Gordon on the previous day. For the first ten minutes, no patient said a word, and I said nothing either, for I had resolved that I would not break the silence this day.

A retired chief, who had been on the ward for ten days, broke the silence by saying, "Some of the things that are said are silly."⁹

Then a very sick, hallucinating, schizophrenic patient began to speak almost inaudibly about how he had been called "dumb" when he was growing up and how a buddy had advised him not to talk to people about his problems. He added, "I don't know what to say, but what I am thinking is that a mutiny in the Marines was caused by my father." Ignoring the speaker's delusion about his father, another patient consolingly replied, "Some people are good at some things and poor at others. You shouldn't feel badly. You should talk to Bill, or Tom, or even (sic) to me, or even (sic) the corpsmen or nurses." (It is notable that he leaves out the doctor.) He then told about a fight he had once had with a sergeant. The conflict between the two had been building up for some time and they had not been talking to each other, he said; then suddenly one day, "The sergeant jumped over and clipped me in the teeth, and all of this wouldn't have happened if he had talked to the boss before, and there wouldn't have been a fight." He was saying, in other words, that it is better to talk; if you talk, your feelings might not erupt into violence. Although he was addressing the schizophrenic patient, it was my feeling that he was really talking to Gordon, for he had told me that he wanted "to hit Gordon in the teeth" for being discourteous to me and that he was afraid he would lose control.

9. The next day this chief, who only on the last day spoke in a meeting, was transferred to another ward where, as soon as his gear was squared away, he went to the corpsman and said, "What time do you have your group meetings?" That afternoon he attended the meeting conducted by the psychologist on his ward, and he opened the discussion at this meeting. In effect he had been, while not active on our ward, prepared for the therapy which was really to take place on another ward.

Now Gordon spoke, sensing that the previous remarks had really been directed toward him. He talked of wanting to forget the past—his alcoholic mother, his failing at everything he had ever attempted, both in the past and now in the service. "Doctors don't tell me what to do, but just ask me what I'm going to do when I get out of the service." He added that he knew, though, that we were trying to help him. Then he stopped and looked around for someone to take this up, but no one responded. After a short silence, I commented upon his wish to forget the past and simultaneously touched upon the need to accept what has happened and to understand it so that he could "forget" it. There are certain things on the "record," I pointed out, that are very difficult to forget because other people won't let you. The fact that he had been in the brig, for example, was a part of his record; and he had told us, I reminded him, that a psychiatrist had made an entry in his record and that his company commander, he felt, had watched him suspiciously forever after that.

At the end of the meeting a chief of many years' service summarized the discussion, more pointedly than I could have done because we all sensed that he was speaking as an "old Navy hand." He said, "You expect a guy to get in trouble on his first hitch, and this is just part of adjusting. A patient's being AWOL and being in the brig for it would be forgotten, and maybe on the second enlistment the record of it would be torn up." Thus the chief brought the discussion to certain realities of life in the Navy, and elsewhere—the elements of time, change, and of forgiveness; the wisdom of going on from where one finds one's self, despite the record; the possibility that others will forget or overlook the past. So I ended the meeting at this point without comment except "Our time is up." But by my manner I was obviously endorsing the chief and what he had said, which tended to increase his status on the ward and, more important, his self-respect, and therefore his well-being.

As the Friday meeting began, two matters which had just been brought to my attention by the nurses were on my mind: a patient had put a cartoon up on the bulletin board, a place reserved for "official" communications from the staff to the patients;

and two patients had engaged in a scuffle on the ward just prior to the meeting, although I was not told which patients they were. If the opportunity presented itself, therefore, I would introduce the subject of social behavior at this meeting, emphasizing the limitations and restrictions that are imposed in the interest of ward decorum.

The discussion opened with a request for more TV in the evening beyond the time limit posted on the bulletin board and complaints that the night lights kept patients awake. Someone suggested that they could sleep with their heads under their pillows, and there was laughter. During this discussion, Jamieson and Harrison, the patients who had been involved in the scuffle, gave themselves away by talking quite hostilely to each other, one of them threatening to pull the other out of the rack the next day if he didn't get up. Then a hallucinating schizophrenic made a request for sedation, and was told to write his name on the list on the bulletin board for an interview about it later. A discussion of sedation now began. Jamieson said that he didn't want to be dependent on sleeping pills; he wanted to fight it out by himself. From this he went on to talk again about the quiet room. At this point, a corpsman dropped his keys. A patient picked them up and handed them to him, but nothing was said about it at the time.

The next topic was a movie that the Red Cross had shown on the ward the night before, about a real professional baseball player who had had a "nervous breakdown" and had totally recovered after a period of hospitalization. The chief, tying this in with yesterday's discussion of the mastery of previous conflicts, said that the movie had not shown how the story really ended. "If you read last Sunday's paper, you'd find out that he ended up by being a great ball player, one of the greatest." Harrison sneered at this, "It ends just like all movies." But other patients jumped in at once, saying that this was real life and that this man had a will to get well. "How did you want it to end?" they asked indignantly, and "Did you see the papers?"

A little later after a period of silence I raised the question about the scuffle on the ward, since no one else had. Did anyone want to talk about it? The silence continued until one patient

spontaneously interpreted it as a fear of "being chewed out." The social worker then reverted to the subject of the movie, pointing out how the boy's father had scolded him and had been unkind. It was at this point that I fulfilled their expectation of "scolding" by referring to the cartoon on the bulletin board and saying a few words about ward decorum. Though I had not mentioned any names in regard to the "scuffle" since the participants had not been identified in the group, at the conclusion of my remarks Harrison said, "I suppose you refer to me and Jamieson. It wasn't a scuffle, but a test of strength." My summary of the meeting dealt in general terms with limitations on behavior and the expectation on the ward that these limitations would be observed.

Throughout this meeting Gordon had sat quietly, but he was a part of the group. He made a significant comment to the nurse, "I came into the group with the wrong attitude."

DOMINATION OF THE MEETING BY ONE PATIENT

Early in the experiment we had our first experience with the type of hyperactive patient who is determined to dominate the community meeting. The patient in this instance was a Marine of Mexican extraction, named Davos, who had been admitted to the ward from a Marine infirmary following a fight in the brig in which he had been badly beaten up by five or six other prisoners, reputedly for talking too much. On admission he was under extreme psychomotor excitation, confused and paranoid, and the diagnosis of manic-depressive reaction, manic type, was evident.

Davos was the sort of patient who ordinarily in a mental hospital would be promptly placed in the seclusion room because he was noisy, disturbing, and threatening. His pressure to talk was so great that his 10-day stay on our ward was later to be referred to as "the talk-talk era." But through the group process, an interpretation of the underlying factors behind this pressure was evolved, and an observable improvement occurred during the 10 days. Although this was only a social improvement, it enabled him to function satisfactorily in the group without sedation, ataractic drugs, restraints, or seclusion.

In his interview with me on the Friday afternoon when he was

admitted to our ward he became quite excited as he described the fight in the brig and told how the guard had stood outside and looked the other way. He even demonstrated on me how he had handled his main tormentor, holding my jacket lightly and pulling me towards him. It was an attempt to frighten or provoke me, and test me, and he said, "Maybe you thought I was going to club you." I asked, "Why should I think that?" He replied, "I don't know." Then I said, "If you were going to, I might have thought so. It never occurred to me."

So in our first interview it was clearly communicated to him that I thought he would not lose control, that I was not afraid of him, and he need not be afraid of me. He then relaxed and told me his life history, the most significant feature of which was the fact that at the age of 7, while his father was beating his mother, he shot his father with a BB gun. This "resulted" in a divorce and the mother remarried. There were five siblings, and the family moved considerably during his childhood. He thought of himself as weak and bullied, and was sensitive about his racial extraction. To overcome his feelings of inferiority he became a successful Golden Gloves boxer, learned jiu-jitsu, entered the Marine Corps, and took considerable pride in his physical prowess. Basically a dependent person, he was chronically hungry for affection and acceptance and group belonging, and suffered severe transient feelings of depression on rejection, with bursts of impulsive behavior, aggression, and feelings of impending violent outburst. At present he was in disciplinary status; he had been sentenced by court martial to a \$150 fine, a break in rank to private, 3 months in the brig, and a bad conduct discharge for being AWOL for 5 days.

When I arrived on the ward on the following Monday morning I found on my desk a handwritten note about Davos from the night corpsman crew: "Tonight when I came on duty Davos was in the nurse's station and seemed a little upset. He was talking very loudly and some of the patients on the ward were getting disturbed. The patient was asked to get to bed but told the corpsmen it would take a lot more than us to put him in bed. The patient was then escorted to the bed and began to cry.

"The patient made the statement that he keeps hearing this

guy's voice, and that he can't remember every word that the guy had said to him. About 0230 there was a buzz at the front door. I went to see who was there, and found Davos leaning against the screen and sobbing. He had come back from another ward and was placed on this ward for the night.

"About 0330, Davos came to the nurse's station and demanded a light. The patient was told why he couldn't have a light. The patient then became very hostile and said he was going out of here in a little while. The patient was in good voice, he had woke up half of the ward. Ferguson was up and urinated on the deck. Patient is very demanding that his needs are carried out and gets very hostile about it.

"The rest of the evening was quiet until reveille.

"Tonight was a little livelier than the usual run for the past weeks. I would like to know how the ward meeting goes today. Signed—Night Crew."

With this information it was clear that we were in for an exciting 10 days on the ward.

At the Monday community meeting, Davos immediately took the center of the stage. It was his first meeting as the Saturday sessions had not yet begun. He talked under great pressure, reliving his court martial, complaining about the injustice of his punishment, the "prejudice" of the court against him, and his counsel's "cowardly conduct." Playing the role of star performer to the hilt, he mimicked the captain who had ordered the sentence and had then told the guards to "shoot to kill if he makes any attempt to break away." This performance was followed by a protest of loyalty to the Marine Corps; he was "Gung-ho," he shouted, and he would fight anyone who criticized the Marines. "It is OK for a Marine to say he hates the Marines if he smiles, or if something has happened to him as in my case."

This was largely a one-man show. No one rose to challenge him; the other patients listened quietly, though there was some tension evident in their movements and muscular gestures. Some of them asked him a few questions of fact, and several cited their own AWOL experiences, in which the period of absence without leave had been longer and the sentence lighter than

in his case. My only comment to the group at the end of the meeting was that Davos felt the need to explain his behavior in this situation to us.

In the staff discussion after this community meeting it was recognized that a more active response of some sort to this patient would inevitably occur. And it did in Tuesday's community meeting. At this meeting Edwards,¹⁰ a schizophrenic patient, immediately threw down the glove with an angry tirade against "those patients who talk too much and too loudly after the lights are out and keep us awake, and those patients who sing all day with TV, and walk up and down, and make all sorts of noise all the time." He declared, "I am shook."

Davos called out loudly, "He means me," and Edwards shouted, "Shut up!" The meeting thus began with an angry attack and a demand that Davos be quiet. But the encounter quickly became slightly more courteous when Edwards amended his statement in a changed tone of voice to, "Knock it off." Davos replied, "Well, you didn't say it right, but I was wrong. I'll be quiet. I'll sit down all day and twiddle my thumbs, and people will say that Davos is sick." There was a long pause after this, and then another patient, who was likewise of a minority racial extraction, spoke up, "People (sic) talk a lot because it's a superiority complex taking the place of an inferiority complex." I remained silent, and Edwards said, "The words are too big. Complexes! All it is is something about their personality. What's that?"

And now an older chief, who had so far been quiet, said, "I read all the time, even though my rack is next to the TV set, and it doesn't matter; I can concentrate." The communication that some people can be comfortable despite distractions

10. He had been admitted to the sick list in Japan with evidence of withdrawal, paranoid ideas, feelings of rage, aggression, and fear of sudden violent action, ideas of reference, and confusion. When I saw him he was obviously tense, chewing on his fingers and his clinched fists, and on one occasion having a chill-like reaction as he blanched in rage. He had minimum ideas of reference at the time I saw him, but was mainly preoccupied with fear that "the thing would come back," meaning the desire to act impulsively, aggressively and violently. Just prior to coming into the psychiatric hospital, he had had a dream that he was caged and people were looking at him. He had been admitted to our ward the day before Davos.

infuriated Edwards. I turned to him and asked if he could not talk about his own feelings. He replied, "No, I can't. I don't think anybody should air their dirty linen in a group. Nobody should talk about their personal feelings. I don't. I won't. I think it's wrong." This called for an interpretation on my part, and I replied, "Nobody is going to insist you do. You are using the group to let out some steam, and that is good, but you can't air your feelings; others might feel differently." "Yeah," he said, pointing to Davos, "some people do." Then he became silent and obviously tense. His fists were clenched, and he was pale and shaking. A growing conflict between two psychotic patients had been brought into the open forum, forestalling the physical expression of violence. The other patients began to talk about playing volleyball together and asked me about the possibility of having a volleyball team from our ward play another ward to help pass the time. It was changing the subject to the more constructive elements of getting along together in the support of the total team spirit. (After the meeting I arranged a volleyball match with another ward and put an announcement of it on the bulletin board.)

In summarizing the hour's discussion, I spoke principally of the intensity of the feelings that had been expressed and touched briefly upon some of the significant remarks made.

After the meeting Edwards, on his request, saw me in a private interview. He sat with his fists clenched so tight they were white except the points of the knuckles. He would not look at me. He said that he had never had a friend and never could be a part of a group. He said he had spells of hatred, so much hatred that he couldn't tolerate it, and wanted to take a gun and shoot up the group or break some object or tear a book apart. I now repeated what I had said in the meeting, that it was all right to talk about his feelings, but added at this time, to me. At this point he cursed the Navy. In the Navy, he said, you always have to hold back your feelings and can never say how you feel. Then his fists relaxed, he looked at me, and the unbearable tension evaporated. I pointed out that maybe the meetings were more important to him than he realized, particularly in the chance they gave him to talk. What he did not realize was that he was

telling a Naval officer exactly how he felt; and, though this was not interpreted, the fact that it had occurred permitted the violent feelings and the feelings of hatred to subside. When I saw him in the afternoon on the ward he came up to me and said, "I'll get along OK now."

At the next meeting of the group the discussion was concerned largely with the question of insanity, though the word was never used. The experience of the past few days had brought forcibly to the patients' minds the fact that they were in a mental hospital; and though this fact was insistently denied, a feeling of stigmatization was obviously paramount in their thoughts. The discussion began with Edwards asking, "What will be the effect on the outside when you want to get a job, and they ask you if you have had any nervous or mental troubles and if you have been in a mental institution?" The group at this point insisted, "No, this isn't a mental institution." Davos expanded the point, "This is a medical ward; there are medical patients here; the captain is a medical patient. I would like to take him outside where he can get some air. He has heart trouble and needs oxygen; he is not a psychiatric patient." We were now seeing a phenomenon that was to be repeated over and over again—the denial of insanity at times when it was staring them in the face. The other phenomenon that we were observing was that when tensions mount because of psychotic patients, the groups soon begin to talk about getting out or getting onto other wards. But, though the others talked in generalities, this time Davos was able to identify himself as psychotic; "Of course, myself, I'm probably nuts," he said, "but I'll deny that I've been a mental patient and I'll confess on Sunday."

Then in quick succession three patients, all of them psychotics, spoke of the stigma that follows an NP patient on his return to duty. One told how an officer who had come from an NP service had been eyed by everybody for a long time. Another told of a ship's captain who wanted to know about everybody who had ever been on an NP service, and an executive officer who knew who they were and watched them. This meant more, they felt, aboard small ships like destroyers than on larger ships

with great numbers of men, such as battleships and carriers. (Frequently the patients struggled with their anxiety over the effect of psychiatric hospitalization upon their future as if, like Melville's Captain Ahab, they bore a grim and ugly scar.)

Now the theme moved to here and now—to the fact that, last night, the Red Cross entertainers had remained "only 15 minutes" on this ward with their singing and accordion playing. The patients had noticed that the singer's hands trembled on the microphone, and someone said that she was upset because Davos had tapped his feet and hummed.

Davos, who had been relatively silent throughout the hour and almost totally silent for the past half-hour, suddenly stood up and talked. He was having a definite flight of ideas, and the old chief said, "You missed your calling; you should have been an insurance salesman." But what was most evident to the group was that Davos and Edwards, if not friendly, were at least tolerant of each other now, and Edwards was less tense and upset throughout the meeting.

At the end of the meeting my interpretation dealt with the pressure that Davos had to talk, to dominate the group, to exclude others, so that he could let us know all about himself and we would understand him, and how he could not tolerate silence—which, somehow or another, meant disapproval—and felt he had to fill silence by his own words.

My concluding remarks dealt with reality: that they were on an NP ward; that they were emotionally ill, or were thought to be so; that one's feelings are important, and if they are in order one cannot be really hurt. At this point Edwards corrected me, "Everybody can take only so much."

In the staff meeting the fact that Davos had stood up at the moment of silence and suddenly erupted in a flight of ideas after a discussion of the entertainers who didn't stay long enough was thought of as his taking the stage, standing up as the singer had stood up. It was noted also that he had taken a prominent chair, pulled out slightly from the end group, which was subsequently known as the speaker-of-the-house's chair because the patient who took this chair almost always dominated the group. It was also interesting that there was an almost theatrical organization

of the patients' chairs. The staff sat across the ward from me, with Davos slightly in front of them. The other patients sat to the right of me in a series of rows of chairs, like an audience.

On Thursday the group returned to a topic which they had touched upon on Tuesday—the topic of prejudice. The meeting began with a period of approximately 10 minutes of silence. Then I said, "There is a lot of silence."

Immediately a chief spoke up, "Well, I'll begin with the question of ward cleanliness. There is no need for cigarette butts to be dashed out on the deck, the bulkhead, and chairs." He scolded the group. Then a Marine said, "It would be OK if everybody had an ashtray, but we will be more careful." I wondered if the chief had been speaking about this Marine, and if his guilty conscience made him reply, but we were never to know this. Again there was silence. Then Davos suddenly began to talk as he had towards the end of the last hour at a moment of silence; but he was interrupted by the chief, who said, "You talk a lot, like my mother." This was followed by another long silence. (In the staff meeting later I was to learn from the nurse that the chief had told Davos before the group meeting, "Remember, give somebody else a chance to talk today," and Davos had replied that he would be quiet.) There was another period of silence, followed by random talk about smoking, drinking, girls. Then the chief told the group that he was happy here for the first time in two years and would like to finish his tour of duty here. Suddenly Davos began his already familiar dissertation on the Marines being above criticism. At this point Edwards, who had been quite friendly to Davos on the ward during the day, interrupted him, "It's a democracy, isn't it? Anybody can criticize. Why should the Marines be above it?"

The reference to democracy led Davos to speak for the first time of his own feelings of inferiority. He talked about being of Mexican extraction and told how, as a child, he was treated badly. Now he was clearly speaking of his feelings and the group were moved by this.

Suddenly another patient said, "It is as if you were a social outcast." These words caused Davos to cringe, but still he sat

by himself, a self-imposed outcast from the group. He was wearing no shirt, as if to show the color of his skin. He spoke with some excitement of prejudice in Japan and then, with an attempt at humor, he said, "We can't even have handkerchiefs on the ward because they are weapons." But there was no laughter in response to this. I countered, "You are getting off the track." He looked startled and I continued, "It is clear that you were getting to the point of a very painful experience in Japan, when suddenly you began to talk about other things. There seems to be pressure of talk as if it were a smoke screen to hide your real feelings."

The social worker asked, "Did you feel this way as a child?" I was sorry that the question was so specifically structured as I was curious if he would tell us about the experience in Japan or his "real feelings."

"Yes," he replied.

And now, Davos having revealed himself, Edwards made an interpretation which was quite appropriate: "He seems to identify himself with the Marine Corps, and criticism of the Marine Corps is criticism of himself."

This was followed by an extremely ambivalent comment by Davos, who spoke of pride at belonging, at the same time denying it. He linked this up with a denial of interest in girls. "I am really not interested in girls. There was a Mexican girl who didn't talk to me but does talk to a non-Mexican."

"Not really interested in girls?" I asked.

"Well, yes," he replied.

And now a schizophrenic patient said that prejudice is caused by the family and that his own social feelings might make him unable to take a Mexican girl out even if he wanted to; that it is the family that influences and directs behavior. Immediately this idea was objected to by several patients: "It's what *you* think that's important, not your family," they argued. "It's *you* who marries the girl."

Then in a strikingly therapeutic observation, the chief quietly said to Davos, "You say you didn't talk much before you came into the Marine Corps, and now you talk all the time. Don't you think there could be some relationship there?" There was silence, and finally Davos replied, "Yes."

At the next community meeting (Monday) Davos moved to sit for the first time in the midst of the patient group.

The discussion began with Davos saying, "May I ask a question?" This social gesture showed a considerable change from his behavior during his first hour, when he had apparently assumed that the meeting was to be used for his exclusive purposes. I nodded in acquiescence, and he recited a series of requests, all of an administrative rather than a psychotherapeutic nature.

This led to further administrative questions; for example, Edwards asked, "How long will I be on this ward, and will I go to an open ward?"

Instead of replying to this and getting enmeshed in the innumerable personal requests and demands which would ensue, I observed to the group that they were dealing with present but rather superficial problems. Immediately a colored schizophrenic patient, who was in his spare moments talking to God, replied, "I went to the doctor for my ulcers, and ended up on the psychiatric ward." There was laughter, but when he added, "There is nothing wrong with me, but I am locked up," others said that it was the same with them.

The chief, turning to this schizophrenic patient, said, "Perhaps you want to live in an ivory tower, away from people." Then he asked, "Have you perhaps overextended yourself, and are in debt?"

It is interesting—and characteristic—that the denial of mental illness by a patient whose psychosis was apparent to the entire group was met first by laughter and then by a very skillfully worded query dealing with the possible reasons for the patient's withdrawing, rather than with the psychotic manifestations of his behavior and words.

Towards the end of the meeting, after there was a difference of opinion as to whether the psychological questionnaire was an attempt to trick them or to help them, Davos reiterated the thesis that anything is possible and that he might be able to accomplish the impossible. The chief then announced to the group that he was going to another ward tomorrow. He also established his special status by telling the group that he had an insurance policy

which paid him during his period of disability, that he himself had no need to worry about a job, that he had 18 years of service, and that he would help Davos get a job with his company.

On Tuesday, the last day on which Davos was a patient on the ward, he took a seat next to me for the first time. On the surface, the theme of this day's discussion seemed to be, "Who will help me?" But there was a deeper theme of resistance, of the danger of talking, of being "helped" versus being "influenced." It began with Davos asking a barrage of practical (i.e., administrative) questions, again introduced by, "May I ask a question?" These were met with silence; and, for the first time, the silence did not bring forth a kaleidoscopic flight of ideas from Davos. Several of the patients then spoke, adding that they were reluctant to do so. Then a hallucinating paranoid schizophrenic said, "We don't need help. Outside we'll have to stand on our own two feet. What has a group discussion got to do with it?" He added, "God helps those who help themselves. Isn't that so, Doctor?" At this point Davos laughed, and the chief scolded, "It is unfair for you to laugh when a patient is talking." Davos explained that he was not laughing *at* him.

The discussion was continued with the idea that there was nothing that anybody could do about their problems anyway. "You have to do it yourself. . . . you have to stand on your own two feet. . . . life is a gamble." But despite their denial of the need for help, the patients probably secretly wanted me (father or older sibling) to help them, and felt to some degree that my silence was a lack of help, for some veiled hostile references were made to doctors; for example, an alcoholic patient said, "The doctor told me if I didn't stop drinking I would kill myself, and I went on drinking anyway."

In summarizing this meeting, with its undertones of resistance, transference problems, and fear of talking, I had expressed to the group my feeling that they had not talked about what was really worrying them. Within a few hours I was to have some understanding, or at least a surmise, of why this was so.

Following the meeting a patient named Allen saw me in an interview on his own request and told me about a nightmare

that he had had the previous Friday night. "Someone was yelling and getting hurt," he said, "I tried to wake up and couldn't. I finally awoke afraid and I couldn't go back to sleep for over an hour. I never mentioned this to anyone before." Later that afternoon I learned from the nurse that a patient in the bed next to Allen's had become "hysterical" on Friday night, and at 2300 the Officer of the Day had placed him in the quiet room for about an hour. This was against the ward policy, and the staff had not told me about it, perhaps out of a sense of shame or fear that I would be angry.

Apparently Allen had suppressed the memory of the Officer of the Day coming to see the disturbed patient and removing him to the seclusion room. But his unconscious fantasy was that someone was being hurt and was crying for help; he had been afraid and had been unable to sleep until the other patient had been returned to the room and his bed.¹¹

In reviewing my notes on the meeting in the light of this direct experience on the ward, it was my feeling that the patients were aware of what had happened—which was contrary to what we had told them would happen—and that, although neither I nor they talked about it, it had obviously influenced the group.

This was the last meeting which Davos attended on the ward. He left us with these parting words, "You won't have a good meeting now because nobody will talk."

11. In this connection the nurse told me of an episode on a closed ward of another hospital, in which a psychotic patient asked the nurse, "What happened to the body?" Upon questioning it turned out that a patient on the ward had been placed in the quiet room and transferred directly from there to another ward. The psychotic's delusion was that the staff had killed this other patient in the quiet room, and he wondered what had happened to the remains.

CHAPTER VIII

FURTHER EXAMPLES OF COMMUNITY MEETINGS HOW THE COMMUNITY DEALT WITH PSYCHOTIC DELUSIONS

The following meeting was one of our early encounters in the therapeutic community with a psychotic patient who suffered with profound delusions. Here, as frequently later, we observed the realistic approach of the group toward them. The meeting was dominated by King, a paranoid schizophrenic. (He occupied a chair on the south end of the ward, slightly forward from the rest of the group and at the edge, a chair which, from this time, was to be known as the preacher's chair. Quite commonly, we observed, it was taken by patients who had intense religious preoccupations as a part of their psychosis and who wanted to talk or "preach" to the community.) The discussion was a very subtle one, dealing with the rather explosive theme of religious differences, in which the group used the religiously preoccupied psychotic, King, as a scapegoat for their fears about insanity.

As soon as we were seated, King began the discussion by asking, "Do you mind if I talk?" And without waiting for an answer, he continued, "I have made a decision that no longer am I going to deal with the Secret Service in the Navy." He then launched into such an irrational, bizarre dissertation on justice and God and evangelical preaching that when he paused for a moment, another patient asked him, "Do you think it's possible that you began with an idea that is not correct; that it is your imagination?" King replied positively, "No." But other patients supported the idea that possibly things are not as they seem, and finally King did admit that he got emotionally disturbed when the Secret Police drilled holes in his car so that it could be used for a get-away for a robbery. As was often the case in the

meetings, the patients ignored the psychotic aspects of this communication, the delusion about the Secret Police. Instead, they vigorously attacked the idea that police would facilitate a robbery. King listened carefully and then immediately said he would like to see the chaplain or go to church but he couldn't do that on this ward. The patients told him that he could. At this point he moved his chair more directly in front of the "congregation" and began to preach. Someone said loudly, "He doesn't make sense." There was no laughter; it was a simple observation rather than a jibe.

Then King went on to tell how the Secret Police were after him, and the Communists were too; and again, rather than dealing with the delusional aspect of his communication, the patients dealt with its illogicality, "Why are you the only one? Could it be that you are mistaken?" I concluded the discussion with an interpretation about religion and about ideas of persecution and suspicion. As I was leaving, a patient commented, "Tune in tomorrow and hear Rev. Billy Graham," but by this time the group had broken up and I said nothing.

As an aftermath of this meeting a catatonic schizophrenic patient who until two days ago had been mute came to my office later in the day and the conversation with him went as follows:

Patient: "I feel better."

Doctor: "How did you feel in the meeting?"

Patient: "Alone. . . . I should have talked."

Doctor: "But you did talk. You said, 'How can I join the ministry?' You asked King this question."

Patient: "Yes, can I?"

Doctor: "King answered that in the meeting."

Patient: "I want to serve God."

Doctor: "But we all serve God."

Patient (quietly thinking): "True. . . . I want to join the ministry when I get out. Can I?"

(Intern enters office)

Doctor: "You can work that out when you are well."

Patient: I don't know the other patients."

Doctor: "Do they call *you* by name?"

Patient: "Yes."

Doctor: "Do they know who you are?"

Patient: (Pause) "Yes. What can I do?" (Now we have turned from "What can I do tomorrow?" in the light of his own delusional system to "What can I do in the interpersonal relationships on the ward?")

Doctor: "You can make friends on the ward."

Patient: (turning to the intern who had come in during the interview) "How?"

Intern: "Ask them their names."

The patient quickly got up and walked out onto the ward saying, "Yes sir." He was seen by the nurse going from patient to patient on the ward, asking their names. I felt that this spontaneous and friendly advice from the intern was appropriate and intuitive. It was short, simple, and effective.

PROBLEMS FACED WITH A VOCAL HOSTILE SUBGROUP

The next four community meetings will be reported in some detail because the group now in the ward (consisting of 26 patients) was monopolized by three hostile, vocal patients—Adams, Blake, and Cooper—who attempted to disrupt and fragment the group. This closely knit trio brought the staff face to face for the first time with some of the very serious problems of self-control and of group participation that were to be encountered repeatedly in the following months. As a matter of fact, this was our most difficult time with this particular sort of dissocial patient during the history of the ward. Whether this was because of the particular malignancy of Cooper, who was a hostile, aggressive "psychopath," or the others it is impossible to say. These patients had been admitted the previous evening and I had not seen them individually before the following meeting.

In the first of the meetings reported here, these three patients sat close together, and Cooper began the group discussion with the words: "We're hill-billys and want hill-billy music—I know the majority won't, but this is our taste." His words had reference to an incident of a minor sort on the ward the day before when, at the request of the majority of the patients, the corpsman had turned off some hill-billy music for another radio

program. This had provoked great anger in Cooper. He now seemed to be itching for a fight, and his mannerisms were extremely provocative. The nonverbal communications were evidenced by the color of his face, the quick flashing of his expression, the clenching of his fists, and the attempt to stare me down. I had the feeling that he thought of me as a policeman. Slowly this hostile clique set about proving that they were the subject of prejudiced treatment.

I did not reply to this obvious provocation. Then, after a pause, Blake said that he hated the corpsmen. This was some continuation of the previous theme, for the corpsmen were responsible for the control of the TV and radio. But obviously it went deeper than this. Now for the first time the patients had expressed an open hostility towards the staff. Following Blake's comment, Adams announced truculently, "*We three are Marines.*" This, I felt, was an assertion of a certain solidarity of the subgroup, not only in terms of their social isolation and difference, but also in terms of their military difference. Now Blake made the first actual sally into the fragmentation of the group with a reference to the privileged majority, "Yah, that's why they got the other music. The majority are Swabbies [we're Marines . . . we hate sailors]." Still only these three patients were talking; the others were listening. None rose to the bait. But the silence, perhaps, and the tolerance of their hostility led these three to go from the announcement of their difference, their hatred of the staff, their resentment at the privilege of the others, to a hatred not only of the staff group, but of the other patients. Blake, who was psychotic and had ideas of reference, was expressing some paranoid ideas, but the others failed to be incited. Then another patient, a sailor, said, "The majority are in favor of the other music. We can hear both. The majority of patients like the corpsmen." But still the three patients went on unrestrained; they spoke of "minorities of Marines" in an attempt to create a chaotic situation where they would then rule by dividing the ward, just as they sat separate from the group by themselves.

Now Adams picked up a magazine and started to read it as a gesture of contempt for the group and for me. At this point Blake obviously had reached a state of intolerable anxiety; he

suddenly stood up, walked away from the group, and then seated himself by a bunk at the fringe of the circle of patients. Until the moment he stood up, I was waiting for an appropriate moment to ask Adams why he was reading the magazine, but now something more dramatic had occurred which I felt demanded understanding or verbalization. A patient had rejected the group because, indeed, he felt that they had rejected him. I turned towards him and said, "Why did you leave the group?" He replied, "I'm afraid I'll hurt someone." This was met with soft laughter from a number of patients, a response which said, in effect, that he would not hurt anyone. Here a patient expressing a fear of loss of control is met not with contempt, but with soft laughter, which served to relieve the tension of the group, and also served to turn the group towards his own problem, for he immediately said, "I can't stand to be laughed at," trembling visibly as he spoke. Something was happening now. One of the triumvirate had deserted; one had turned to a magazine; and the one who had deserted had given to the group an important symptom, namely, an idea of reference. The spokesman of the triumvirate now dominated the rest of the hour. On two occasions when I spoke he interrupted me. The group process in relationship to the minority and prejudice problem was verbalized by a Negro patient, who spoke about the way minorities are and the problems of conformity.

Then a patient asked Blake, who was visibly tense, afraid, and angry, "How long have you been on the ward?" This, I felt, was a status communication of the patient who had been on the ward longer than Blake, and was not intended as a provocation, but rather as a plea to wait and see. But Blake in his anger said, "All I want is to get out." He avoided replying as to the length of time he had been on the ward, and the patient who had queried him continued in a sophisticated therapeutic comment: "You and the rest of us, brother." One of the hostile patients has been made a "brother." At this point Cooper was waving his pencil at me in a symbolic gesture, or at whoever talked. His hostility toward me or toward any leader with whom he must vie became intense, and it seemed to him at this moment that the group was a public forum—a Hyde Park for expound-

ing a personal idea of his, but not for discussion of the personal feelings of others. As the hour was drawing to an end I pointed out the isolation of the three patients who sat together and the antagonistic way in which Cooper's complaints had been presented. In summarizing the hour's discussion, I acknowledged his complaints by simply repeating them, mentioned the rules of the ward, and explained that we were here to discuss the feelings of the group. At the end, he shrugged his shoulders and said, "Well, have it the way the majority want." Blake said, "All I want is to be left alone; I don't care." Adams sat silently reading.

Staff discussion following this community meeting was concerned primarily with the sado-masochistic aspects of the subgroup, particularly Cooper. It was observed, in review, that the group had tolerated belligerent talk and implied threats; that an opening wedge had been made in the subgroup; and that Cooper's final contemptuous comment about the majority was, in a sense, an acknowledgement of the limits set by the rules of the ward.

But the main reaction of the staff was surprise that they had felt comfortable in this meeting and an intense curiosity as to what would follow upon such an explosive, angry hour.

(After the community meeting I interviewed each of the new patients for their initial evaluation. When I asked to see Blake, Cooper walked up and stood by to hear what I was saying to him before we walked into my office. Shortly thereafter I got a message from the corpsman that Cooper wanted to see me. Though there was a list on the bulletin board where patients could write their names to see the doctor, he refused to do this and wanted the corpsman, indeed directed him, to give this personal message to me. When I returned to the ward I wrote his name myself on the list to see him in turn. He was obviously angry, and the next day showed his anger by refusing to shave.)

Tuesday's meeting was essentially depressed. It seemed to me that a reparative process was taking place, a group-healing phenomenon, but also with some elements of regression. We were to observe repeatedly that after an extremely excited, tense meeting, particularly with a hostile spokesman, the groups could

not tolerate carrying on. But today the subgroup had already been divided, and this occurred in an interesting fashion. By coincidence, and contrary to ward policy, Blake was at Psychology having tests at the time of the community meeting; but before he left he had come to my office to confide to me that he did not like Adams. The fact that he should have come and confided this alone to me was, I thought, highly revealing of his needs and defenses. Properly handled, if he could count on me, I could count on him. Now Cooper and Adams were also separated in the group, physically and in many other ways.

The meeting was a strangely silent one. For ten minutes nobody said a word. Perhaps the patients were intimidated by the rift and by the sullen, solitary presence of Cooper, who sat at a table just beyond the group, with his back to us, drawing pictures. For two reasons, I made no effort to draw him into the group. First, I felt that such an effort would be likely to fail, and I would put him in a position of defying authority and succeeding. Second, it occurred to me that he had not removed himself so far that in reality he was not present in the group, and this turned out to be the case.

The meeting began with a question from an alcoholic patient as to why he drank. But this question was not motivated by any genuine feeling or accompanied by any nonverbal communication which would have told the group that he really wanted to know or that he was troubled by the drinking. Rather, he was attempting to help me and to help get the ball rolling by turning to me in my conventional role as psychiatrist for an explanation of a psychological difficulty. His question was met by silence from me, and he turned to the others and asked them what they thought, but no one replied.

Meanwhile Cooper looked over his shoulder once in a while, indicating his anxiety at being apart and his need to keep an eye on the group. Adams sat by himself at the back of the group, but now participated after I pointed out that perhaps the silence might be related to yesterday's meeting and that Cooper's sitting apart from the group might mean something. At this point Cooper retorted, "Rebels!" The response to this was laughter, in which he himself joined, adding, "We got to hear hill-billy

music yesterday, when the majority of patients were in the courtyard, but it was turned back when they returned."

After a prolonged period of silence I played a short phonograph record, "The Unwitting Influence of One upon Another," in which the "antisocial" behavior of a little child is fostered by the father's unconscious wish for such behavior and expectation of it. I had already known from the staff meetings that the very sickest catatonic schizophrenic had seemed to "come awake" during yesterday's meeting, and so I turned to him and asked him what he thought about the record. The technique of calling on a patient I rarely employed, but in this instance I felt that perhaps he would talk; and since he had been mute for the entire time on the ward, it would be meaningful to him and to the group. Rather than asking him to perform, it was to master a symptom. He responded, saying, "There is something in my throat—I want to get it out. I have a feeling it is from the record."

On the third day Cooper remained in his relatively isolated position, and Adams sat beside him. But the triumvirate had divided, for Blake now had rejected the subgroup in favor of the majority. (We found in the antisocial subgroup, just as we were later to find with Negro patients or other racial groups who isolated themselves, that when one deserted, the subgroup had lost its power.) They no longer stood together; they were no longer "the Marines." One had become a patient, and perhaps the others wondered about themselves.

Thursday's meeting was different from the preceding ones. The patients now sat in a very wide circle, no longer close to me. Cooper and Adams sat alone on a bench at the edge of the group. Two things had happened the night before which I did not know about until after the meeting. One was that the three patients referred to as the triumvirate had taken beds adjoining one another, and had kept the other patients awake intermittently all night by talking loudly. The other thing was that the nurse during the day had said to Cooper, "Get out of your rack or you won't be able to sleep at night," and he had replied, "Then give me sleeping pills."

The group was not silent or depressed as yesterday, but it was not "together" either in the sense of being close. It was together, however, in the sense of a theme which carried through the entire meeting—the theme of sedation and insomnia, the nighttime and dreams, the common group tension.

The discussion was begun by the same alcoholic patient who had unsuccessfully attempted to be the doctor's helper in the previous day's meeting; but this time there was response because his communication was obviously deeply felt and community-shared. He asked the group, "Why do people have trouble sleeping, and what do you think about sleeping pills?" The group took up this theme and, without any communication from me, expressed the view that sleeping pills were best avoided if possible. Then a very psychotic schizophrenic patient said, "I had a dream once in which my 12-year-old brother was riding a bicycle and fell off a cliff and was killed." The patient then laughed. The group seemed startled and none laughed. I asked him if he had any feelings about the dream and he said, "No feelings. It was just a dream." He thought for a while and added, "I felt bad in the dream." Then the alcoholic patient who had begun the discussion related a dream that he had had the night before: "I dreamed that I was on this ward for three weeks, and my eyes were red and Dr. [Smith] said, 'You are still not dried out, and have to stay here.' It was a crazy dream about Dr. [Smith]." The response to this dream was laughter, directed toward the "other doctor" and arising from the connection of the ideas "crazy" and "doctor."

But both of these dreams were meaningful. In discussing them later on with the group, I pointed out that the dream of the brother's death might mean that at some time the patient had wished that his brother was not around, and the dream of having to stay on the ward was a fear that yet contained an explanation of why the patient was on the ward "so long." Perhaps he was still not "dried out behind the ears," in a sense—that is, not well enough to go out on his own. The patients listened attentively and made no comment. Then a man who had previously been silent said, "How long are dreams? I've heard they last only seconds. Do people dream all night?" The

time was up, so I summarized the meeting without answering this request for information, which in its context and its timing did not call for an answer.

As I walked out the door I was stopped by Cooper, who told me, for my "own information," that dreams last from 3 to 15 seconds. I suggested that he should tell this to the group. He replied that he would not join the group because, "You singled us three out." "Well," I replied, "You singled yourselves out," but this was said without anger in passing as I made it a policy never to engage in long discussions with patients after meetings. The significance of his comment was that he had been silently participating in the meeting all the time—that is, in a sense had been there—and that he was projecting upon me his own feelings of being singled out or being different.

In the following staff meeting, discussion concerned sedation, insomnia, and the problem of patients lying on their racks during the day. One specific situation considered was that of the nurse telling Cooper to get out of his rack or he wouldn't sleep at night. I suggested to her that it might be preferable to say, "Now is the time to get out of the rack," without adding the comment about not sleeping at night, because it invited a request for sleeping pills, which then had to be refused as a matter of ward policy. Had she issued her order or request without an "or" she would have spared herself an "or else" type of comment designed to frustrate her.

The corpsmen were apprehensive about how they could deal with a patient's refusal to get out of the rack unless they had the authority to "do something" about noncompliance. One corpsman said, "If you threaten (sic) them with the quiet room, the patient then knows you mean it and can do something about it." I pointed out that he was obviously thinking of the quiet room as punishment, which it should never be, and that he was discouraged by being denied this means of discipline; also that, although a certain sort of ward behavior is expected and in a sense demanded, we will not always get it. But if we threaten with an alternative, manipulative patients will behave in such a way as to force our hand. When the corpsman finds himself unable to cope with the patient, the situation should be dealt with

by the doctor. In this way I communicated to him the feeling that he was not alone, that if his request or command was not met it was then a matter for individual discussion between the patient and doctor, in which I would support him.

On Friday the meeting was extremely different because Cooper had been transferred to the brig. This was in keeping with established administrative procedures and neither he nor the other patients—so far as I know—consciously associated it with the preceding material. It is interesting that, with this disruptive member gone, the group now turned somewhat eagerly to questions of ward morale, neatness, orderliness, consideration of nurses, and squaring things away. This was the reparative process without the regressive elements.

The discussion was begun by a patient who had been admitted the previous evening after a serious suicidal attempt. He complained that patients should wear the tops of their pajamas out of consideration to the nurses. There was little agreement with him, and the nurse commented, "Sometimes it gets hot." Then he suggested that they should keep their pants pulled up, that some let them hang down. The staff now began to talk. Throughout the entire time that the disruptive trio was on the ward they had been silent. The corpsmen now described difficulties with the galley detail, and the patients said that they would help. Adams had now joined the group in being a therapist. The catatonic, previously mute schizophrenic did not join the group, and after a time Adams walked over and talked to him, and they came back and sat together. There were complaints from the patients about noise during the quiet hour, and the topic of monotony was raised, probably in anticipation of the weekend.

In their meetings the staff discussed now, as rather keen observers of behavior, the group movements, attention, reactions, and visible emotions, such as blushing and blanching, which they had observed in the patients during the meeting. So the week came to an end, and we had apparently mastered a major crisis.

TROUBLED TIMES WITH A "FAVORITE SON" SITUATION

When the following series of meetings occurred, the therapeutic community had been functioning for a number of months, and the staff had considerable confidence in themselves and the community. The period they cover is not cited as a "typical" period on the ward, however, but as one which called upon all our resources to an extraordinary degree.

The story is essentially that of a 21-year-old patient named Smith. He was an enlisted man who, after his initial training, had spent 20 months with the Navy in Guam. During this time he had written home every week, and the family had not suspected that he was in any way sick. But when he returned home for a 30-day leave, his parents immediately noticed that he was irritable, could not stand criticism, and would burst into uncontrollable sobbing on the slightest provocation. He slept very little, and he talked frequently with his mother about strange ideas that he was having. Then one Sunday morning 10 days after his arrival, he announced to his startled parents that he was God.

The next day he was admitted to a hospital, where he was diagnosed as having an "acute, severe, paranoid schizophrenic reaction, manifest by ideas of reference, excessive religiosity, and various types of unpredictable behavior, with marked psychiatric impairment." A week later he was transferred to the Naval Hospital at Oakland by air.¹²

12. The note from the previous hospital read: "For the most part he has been cooperative. He has not been destructive in any way. The only disturbance he has created has been noisy behavior. The noise became so disturbing to the rest of the ward after two days hospitalization that it was decided to start the patient on chlorpromazine, which he received intramuscularly. This has not appeared to have too much effect on him."

In his admission interview at Oakland, he sat stiffly in the chair, always using the designation "Sir" when speaking to me. He walked stiffly but seemed reasonably calm. His mood was variable but hardly ever appropriate. He was bland, expressionless, and then suddenly he would become silly, and he would smile and be almost euphoric. He was oriented but confused, though he could see the points of confusion when they were pointed out to him. At moments he recognized that he was sick and at other moments he denied it, speaking of his "happiness" and "union with God." In fact, one of his delusions was that God was bottled up inside him, and that he himself was an actual image of God. He described auditory hallucinations which were not recorded at the previous hospital; the voice of God now saying to him, "Hold up your head," and "Do right and be good."

The group gathered quickly for the meeting on Tuesday, the first meeting which Smith attended, and many of them had already taken their places before I walked in. Smith sat in a cluster of patients at the south end of the ward with his chair drawn slightly forward in a prominent position. He spoke at once, "What's this all about?"

I explained simply that we gathered here every morning "for the patients to say whatever they want to." It is extremely unlikely that my explanation of the group's purpose was very meaningful to him. But he most certainly took me at my word. From that moment on, it was Smith's hour, with very little verbal participation by the other patients. Flexing his muscles and striking his chest, he began in a loud voice, "I am growing. I am a giant! I am going to be a giant and demolish the demons. I want to go home when you think I can. I made a pact with God that if I came back to the States alive I would give myself to God.¹³ Again flexing his muscles and striking his chest and smiling even while saying sad things, he told the group, "I'm a gorilla without a tail."

I made no response to this recital of delusions. Then he told us a story. "When I was young," he said, "the basketball coach said to me, 'Smith, you're going into the game.' Then at the last moment he changed his mind and sent someone else in. That killed me." The memory about the coach struck me as a screen memory, perhaps having some relationship to sibling rivalry and to feelings of devastating consequence to his pride and perhaps in fantasy to himself.

The other patients listened attentively. He had communicated to us about his somatic delusions, his paranoid ideas about demons, his auditory hallucinations about God, his religious pre-occupations, and his fear of death and of being killed. He had followed this with an interesting account of an experience which had metaphorically "killed" him.

From here, Smith moved on to a series of metaphorical communications in all of which there were obvious paradoxical ele-

13. These three metaphors were clearly delusional and they were also paradoxes, wishes distorted through his psychotic thinking. They told us nothing, yet, about him as he now was, only that he was in the process of changing, and of uncertain body image.

ments. He told us first about his younger brother, who was bigger than he. This was indeed a paradox—the smaller child is the bigger child—and might have something to do with his wish to be a giant and also with the sibling rivalry in the basketball situation.

This was followed by several references to death on Guam and then by the statement that he had been "a man there" . . . "I'd only had fuzz before, and my mother used to say I had curly hair."¹⁴

At this point the social worker, in a conventional historical way, asked, "When did you first begin to feel this way?" This question lead him again to Guam, where, he reiterated, he had been "a man." He went on to say that on Guam he had associated only with the colored people; they had been his friends and had helped him (i.e., had loved and cared for him). Here again the paradoxical quality of his communication was apparent. Though he was asserting his manhood, he was telling us that he had needed help and love and that he had turned for it to the minority group, probably because of his schizophrenia, but also because he felt rejected by his own people.

I interrupted him at this point to ask, "Do you think you are sick?" (i.e., "How do you feel about yourself now?" rather than, "When did you first begin to feel this way?") He categorically denied that he was sick, but immediately followed his denial by asking the group for "help." The group, though attentive, met this in stony silence. I pointed out the inconsistency of asking for help if he wasn't sick and suggested that perhaps he was aware that he was "not quite himself." In reply, he made a rather extraordinary comment, right back to reality observations of himself: "Ordinarily I am a shy person and can't talk, but since I had psychiatric help in an Army hospital I've been able to get everything out." This was recognition of sick talk and well talk; of how he behaved at one point and at another. It was also an appreciation and admission of the fact that he was not quite himself. I interpreted here by commenting, "You

14. These next three statements were paradoxes in metaphor, relating to the real past—one happened in fantasy, "this killed me"; one "shouldn't" have happened—little brother is big brother; and one was a clear inconsistency: a man with fuzz.

say you are not sick but you ask for help, and you are aware that you are not quite yourself."

At this point he again appealed to the group for help, and when no one replied, he turned to a patient who looked slightly Oriental and began speaking to him in a schizophrenic gibberish which he called "Japanese." Whether this behavior was a gesture of contempt or some complex schizophrenic effort at exotic communication or simply a bit of fun, was not clear at this moment. I said to him quite pointedly, "This doesn't make sense, but what you said before was sense." He immediately tried to get back on the track by saying, as if his disorientation had suddenly dawned on him, "Where was I?"

Then he said, "If no one has anything to say, I must be right." I replied, "Everyone is listening to you, but the fact that they don't say anything doesn't necessarily mean that you are right. Perhaps they are silent because they think that you are sick and somewhat confused.¹⁵ This idea apparently had an appreciable effect on him, for he immediately said, "Yes, that's right. Keep talking, Doctor. I'm listening." Thus he agreed to the proposition about himself which he had immediately denied when he had first been directly confronted with it.

At this point some sense of the feeling of the group was suggested by one patient turning his chair with its back toward me as if to say that he was out of the group which was just Smith and me. I asked him why he had done this, and he turned his chair back, saying, "I don't usually act this way."

The hour was now over, and I began the summary of the meeting with a story about a little boy who had a camera and took pictures of his family. But because he had to point the camera up towards people, the pictures showed everyone sort of distorted and very big, as if they were giants. Even his brother, who was younger, looked very big. Then I spoke of how the father seems very big and powerful to the small child, who can't imagine that he will ever himself be that big, and how the child thinks there is something unusual about a younger brother

15. This was not only a reality interpretation but a partial resolution of a paradox —i. e., all statements here being made are true . . . (even the false ones). The interpretation said not necessarily so at all. He feared that if he reached out he would be rejected. Silence and punishment seemed closely related.

being bigger than himself. Here Smith interrupted me, and said, "I shouldn't be talking like this. I may get thrown in the brig."

I made no comment on this, for no amount of denial would penetrate his delusions. The only meaningful basis on which to meet the fear he had expressed here would be to let him see for himself that he could say whatever he wanted to without dire consequences. I expected to see him markedly improved the next day.

The Wednesday meeting was one of the most difficult and unexpected sessions in the experience of the therapeutic community, marked by the most flagrant deterioration in social behavior that occurred during the ten months of the experiment. It was the only time that I had to send a patient out of a meeting, and the only time that I felt it desirable to inform the group that medication would be given to a very sick disturbed patient. On the other hand, it showed us the degree of tolerance and patience which the community had for its sickest members and efforts that the other patients made to control their own aggression. It showed us also that they themselves were seeking for the cause of the patient's behavior; in fact, it was one of the patients who gave me the clue to what had happened.

When the meeting opened, Smith was walking restlessly around and shouting. The chair which he had occupied yesterday stood empty and apart. I asked him to sit down in the group, but he categorically refused. And he not only refused to sit, but began to spit repeatedly on the floor in contempt and disdain. When he was told to clean it up, he took the toilet paper given him by a corpsman and tore it in pieces and scattered it about like confetti. Then he turned and angrily called me a son-of-a-bitch, adding that he was spitting out the devil. I was at a loss to know why he had changed so dramatically and why he chose to show such contempt for me. I was also at a loss to know just what to do. It was our first encounter on the ward with such total defiance of expected behavior, and the first time that a patient had not been reachable at any point. I commanded him to stop, but without effect. He continued to spit, flung himself upon a bed, arose and then came over and put his arms around me from

behind, sitting down back of my chair in a rather seductive fashion. After this, he walked over to another patient and threatened to hit him. No one moved to restrain him, and the threatened patient pushed him away. Smith, exaggerating the force of the push, fell to the floor, rolling and spitting so voluminously that a chorus of horrified protest arose, "No! No! Stop it!" The revulsion which the patients felt was palpable.

He stood beating his chest and shouting, "I love everybody. I want to kill everybody."¹⁶ He had, in effect, said by his gestures, "Love me," and then had spoken of his ambivalence about love. It was clear to me that he would not conform and that we had reached a crisis. Action necessary, I asked a corpsman to take him to my office. (This had never been done before, and was never done again after this meeting.) It was not clear what this action meant to the patient, whether he thought that he was being expelled, "sent to Siberia," rewarded, imprisoned, or simply being faced with the limits on behavior set for members of the group, or whether it was utterly incomprehensible, as the world was all mixed up and crazy to him.

As soon as he was out of the room another patient made a rather remarkable observation; he had noticed, he said, that Smith's behavior had changed dramatically at 5:00 o'clock yesterday. The question was, Why did this happen? The patient who reported this thought it had something to do with Smith's physical examination by the Korean resident doctor who was now working on this ward. He said that Smith had been "perfectly all right" following the group meeting up until 5:00 o'clock. Then he returned to the ward suddenly stiff and rigid, lay upon his bed, began to talk in an increasingly strange manner, and seemed to lose control; and his behavior had since been mounting continuously to a peak, which was reached when the meeting began.

One patient said he would like to hit him, and I commented that this wouldn't do any good. Another said that Smith had hit him over the head with a banana and that he had given the banana back to Smith. It was now obvious that Smith was pro-

16. He now conceived of himself as a gorilla, a giant, a dangerous monster—the completion of his delusions initially communicated to us, a sharp regression.

voking those patients who would respond most aggressively; and he had, by a sensitive schizophrenic process, been able to recognize those patients with latent homosexual problems, and had provoked these patients, who now began to express their hostility in the meeting. One patient said that he wanted to kill him, and he said it in such a manner that I felt compelled to reply, "Nobody is going to kill anybody."

One patient, a big, strong man, was shaking and admitted he was afraid he would lose control: "How long can one put up with this? How long will I be able to hold myself in?" While the sexual implications of the expectoration and many other things seemed apparent to me, the social meaning seemed even more striking. It was *as if* the group were saying, "If you expect to rate with us, don't expectorate on the floor."

I then told the group that I would bring Smith back if it was agreeable to them. There was no objection, so the corpsman brought him in. The patient who had pushed him immediately began to talk to him, perhaps to relieve his own homosexual anxiety and perhaps also to manifest behavior that he thought would please the doctor, since he was being transferred to an open ward after this meeting. Regardless of the motivation, it did seem to have a momentary therapeutic effect on Smith, for he subsided. But then, in a burst of uncontrollable behavior, he tried to put his arms around me, crying, "Play with me. Love me." After this he began to spit on the floor again, and it was again necessary to send him from the room.

Now perhaps this meant to him, "Go, I will not love you," but the meaning was not yet clear. In summarizing the meeting I discussed Smith's behavior; and, since they were having some obvious difficulty tolerating it, I told the entire group that I was going to give him some medicine which I hoped would help control his behavior (an ataractic drug).¹⁷ But I emphasized

17. It should be noted that in the previous hospital, as on this ward, the drug was given to Smith as much for the benefit of the other patients as of him. In the previous use of it, over a period of 3 days, it was thought to be ineffective. On our ward, its use was followed by a noticeable effect within 24 hours. This case, it was thought, represented an exceedingly interesting situation in which the drug, without additional factors, was ineffective and, with additional factors, was highly effective. It was also more urgently needed, and perhaps its administration was associated with more hope and interest by the staff.

that he needed help from the group. I pointed out that yesterday no one in the group had talked to him and that his strange behavior today could be caused by a feeling of rejection and a desire to get their attention, even in a "crazy" way. I pointed out also, regarding the question, "How long can you tolerate this behavior?" that human beings can endure a great deal longer than is usually thought, particularly in moments of trial. I ended by saying that although some of Smith's behavior was "willful," it was quite irrational and he was very sick. On this point a patient disagreed with me, saying that it was all an "act put on." But the group as a whole was willing to try to help the patient.

In the following staff meeting I learned the circumstances which had precipitated Smith's behavior in the meeting. The Korean doctor who had examined him at 4:30 Tuesday afternoon had performed a digital rectal examination. It will be recalled that the patient said that he had become a man in Guam and that he had associated with a minority racial group there exclusively. The obvious awakening now of his homosexual anxiety was more than he could tolerate. And in his acutely disturbed state he did not distinguish between doctors; so I became the "son-of-a-bitch" and the object of his ambivalent and perverted affection. He had provoked patients and would continue to do so; and he was still to pay for this provocation and for the homosexual anxiety which he had aroused and which was one of the most difficult factors on a closed ward such as ours.

The staff were surprised at my anger in the meeting, commenting upon the fact that even such behavior as urinating on the deck was tolerated. Why was it that spitting was so terrible, they wanted to know. Had the intensity of the group reaction been caught from me? Was my feeling about it related to the fact that I had once been a tuberculosis patient in a sanatorium, they asked me.

On Wednesday night there was considerable insomnia on the ward. But the group decision towards the end of the last hour to try to help the patient had apparently made an important change in ward attitudes. The doctor and the patients had in a sense gotten together. Some evidence of this could be obtained in

the seating arrangement at the Thursday meeting. The patients gathered quickly. No patient sat opposite me, and none behind me. They formed a large semi-circle to my left and my right. Smith was sitting to my right at one end of the ward, and all the patients who had been made most tense and anxious by him were grouped at the end opposite him. The patients near him either had their backs turned toward him or avoided looking at him by glancing down. My fantasy was that this seating was counter-phobic, and those who could not bear to look at him sat in such a position that if they raised their glance they would have to look at him. Smith, sitting behind another patient, had moved somewhat into the group.

The meeting began with a patient saying, "Are we going to have any special chow today?" (It was Thanksgiving Day.) I replied, "I don't know."

Then Smith called out, much as he had at his first meeting, "What's this all about?" But instead of following this question now with his delusions and hallucinations, he added brightly, "What do you have to talk to me about, Doc?" This question was a sort of reversal of what he would have liked me to say to him, as though he and I took a sort of precedence over the community. I met it with silence, and he made a mock spitting gesture—his gesture of contempt and anxiety—though he did not actually spit. But when he perceived the facial expressions of the other patients, he explained "This is due to tobacco from the cigarette." He was offering a socially acceptable reason for his spitting (though it was still psychotically motivated). Two or three times later during the hour he looked as if he were going to spit, but he never did.

Since he had been unable to establish any satisfactory contact with the group in the manner in which he had gone about it, he now began talking steadily, not with the purpose of communicating to the group, but with the purpose of excluding the group, perhaps as a phenomenon of jealousy. Other patients who wanted to say something found it impossible to break in. Finally Burton who, as it later turned out, was the most jealous of the domination of the group and of my attention, shouted "Cut it out! Behave yourself!" Smith stopped talking at this,

but he now put his feet up over the back of another patient's chair in a new gesture of contempt (wiping his feet). I said, "Put your feet down. We would not let anyone else put his feet on your chair." He obeyed.

Smith again began to talk, now in a schizophrenic gibberish, though not the pseudo-Japanese, which he seemed to reserve for special occasions. At this point a patient whose first name was Don interpreted the need for him to be quiet by saying, "Nobody else can talk when you talk. Now shut up!" Again Smith's reaction was socially acceptable: "Yes, I will," he said, "I'm sorry." Now Don made a belated reply to Smith's initial question by lecturing him on exactly what the meetings were for. Smith replied, "Thank you, Doc. I mean, Don." This did not appear to be a slip of the tongue, but a conscious reversal of roles in a sort of pun, expressing both "gratitude" and a subtle depreciation of the doctor for not answering.

It was only at this point that I was able to return to the initial communication of the hour—the question about special chow, about Thanksgiving Day and about being away from families. This led Smith to announce, "I'm going to knock the door down. I'm going home. I'm lonesome. I want to leave."

It will be noted that in the first meeting, when he spoke of wanting to go home, he had spoken in terms of delusions: namely, that he was growing to be a giant and that he had made a pact with God. Now, while he still speaks in a delusional sense of his strength—"I'm going to knock the door down"—he expresses himself as any of the patients might have. He not only says he's going home and that he's strong enough to knock the door down, but he explains why, as he has explained other things in this group—that he's lonesome and wants to leave, and also he makes some expression of disappointment and anger directed towards me, for he is going to knock down the door of my house.

Since the other patients were hardly able to talk because of Smith, I now played a record—a technique which I used occasionally when a very sick patient had dominated the group for a prolonged period of time. The record which I chose on this occasion, "The Wantaleaver," tells about a patient with tuberculosis

who wants to leave the hospital against the doctor's advice.¹⁸ Following it, there were comments from a number of patients about rebellion, big people and little people, delinquency, parents' attitudes, and the fact that parents sometimes do just the opposite of what they say—all themes suggested by the record. The group were greatly relieved to have a "neutral" backdrop on which to project their feelings.

But Smith could not tolerate this for any prolonged period, and he began to talk and act very strangely. At this point, Delaney—husky, large, and trembling—stood up and walked to the solarium. I turned to Smith and said, "Stop acting crazy." This interpretive command had a profound impact, but it was, of course, a double-edged sword, one which I rarely used because of its misuse by patients to support their wish to deny insanity or as punishment with the "support" of the doctor's imprimatur. If it is used it should not be for the dramatic expediency of the moment but with full awareness of its use. It should be, in effect, an interpretation and never an accusation. For the moment, however, it worked. Smith immediately stopped his bizarre behavior, admitting that some of it was put on; and, since my comment had been perhaps somewhat traumatic, I followed it by saying, "You are better today." He agreed and seemed relieved.

The discussion was summarized at the close of the meeting in terms of the following themes: loneliness, Thanksgiving and the thoughts of home, and the desire to be away from the hospital.

The tension which had preceded the Thursday meeting had broken, and the night had passed in quiet. On Friday, there were no comments to me at sick call, and only two patients put their names on the list to see me during the day. The seating arrangement was almost identical with that of the previous day, with the patients who were most anxious sitting away from Smith on the south end of the ward and the others sitting on the north end of the ward with Smith. As the group began Smith was

18. Like a number of the other records which I used with the group, it is from the series, *This is Your World*, which I had composed and previously used in group therapy with tubercular patients.

quite active, walking about, hallucinating, making largely inaudible comments, one of which could be heard, "Say something to me." After about 15 minutes he said, "I have something still to say." (Pause) "No one sits close to me."

Shortly after this he walked over and sat in a chair at my right hand for 5 or 10 minutes, and then moved to the south end of the ward and seated himself with the patients who were made most anxious by his presence. Apparently his comment, "No one sits next to me," referred specifically to the patients whom his anxiety had alienated, as if those who sat by him did not count, as if the only people who existed on the ward were those who sat away from him. All this time he was whistling and shuffling his feet. I interpreted this by saying, "You seem to be making noises and shuffling your feet to let us know you are here; that is, filling the silence with noise. You also seem to be better today." He readily agreed with a nod of the head.

Suddenly he announced, "My feet are getting smaller. My shoes are bigger than my feet." (Pause.) "My shoes fit." I asked, "Does this mean that you are now down to size, more like everyone else? You are trying to find yourself, your own size?" He nodded his head in vigorous agreement, and seemed quite relieved. Obviously, of course, this was still a delusion, but the delusional system was going in the direction of normality rather than abnormality. But he would still spit occasionally.

Then he said, "I used to want to wear a sailor suit. I love that sailor suit," and he laughed. This had a nostalgic, sentimental ring to it; and hoping to utilize it to bring the discussion back to the period from which this sentiment came, I asked him if he had had a sailor suit when he was a little boy. He laughed and said, "Yes, when I was 5 or 6." I turned to the group and said, "I wonder if anyone else has any memories about sailor suits?" The chief, in his loud and rasping voice, immediately replied, "Yes, I have something to remember—30 years of wearing it!" This comment brought a great burst of laughter which relieved the tension of the group and even of Smith, who stopped all his mannerisms and mildly disturbed behavior. I too couldn't help but laugh, and acknowledged, "I get the point."

The discussion now took the direction that I had hoped for when I asked the question about sailor suits—toward childhood. Delaney asked, "What is the cause of juvenile delinquency?" Burton thought it was caused by parents "saddling and reining their children as if they were horses." He spoke of how much rope it was possible to give. Another patient commented, "Rope enough." These words related to a line in the "Wantaleaver" record played on the previous day: "The horse thinks one thing and he who saddles it another." Now another schizophrenic patient, who had not previously spoken, said, "You can always go home again." I phrased an interpretation in a way which, I hoped, would succeed where my earlier one about sailor suits had failed: "An author by the name of Thomas Wolfe has written a novel called *You Can't Go Home Again*, and I wonder if it's ever possible to go back?" Although I think this was a clumsy way to interpret, the feeling behind it, the timing and the relevance strongly counterbalanced its awkwardness. The patient to whom this was directed looked quizzical and then depressed. "No, probably not," he said. There was a pause of profound silence. Then Delaney returned to yesterday's theme of loneliness and of leaving, which was probably what he had meant by his question about juvenile delinquency: "Is it true that children are always lonely when they leave home?" Several patients agreed that this is true. There was a pause and Burton commented, "When I think about delinquency I think that policemen have been the people who have always helped me. I had an alcoholic father. I loved my mother and I would murder for her."

Immediately I asked, "Murder whom?" There was silence. At this moment Smith, his anxiety activated, became visibly restless and started to stand. The patient sitting next to him, now acting as his spontaneous therapist, said, "Sit down"; and to complete this cycle in relationship to father, Smith replied, "Yes, Pop." Now he lighted a cigarette, and his "therapist" handed him an ash tray, saying paternally, when Smith shrank from it, "It's not too hot and you won't drop it." Again Smith said, "Yes, father," and then began jabbering gibberish. He started to spit, but refrained when his "therapist" held him

gently by the arm and said, "Knock it off!" The control which this patient had over him was quite dramatic.

Then Smith said, "I am the nervous type. I am getting shaken here." (These two comments are not unlike his clarification in the first meeting, when he was brought back from speaking gibberish to say, "Ordinarily I am a shy person and cannot talk.") He is speaking now of present realities—of the fact that he is a "nervous type" and that he is "getting shaken" by what is happening to him in the here and now.

Following this, he made a most revealing statement, "We (sic) can't get out." This was his first real verbal identification with the group but it was followed by silly behavior. He began drawing heavily on his cigarette and blowing out a great cloud of smoke. "This is a train letting off steam," he said. And then it was an airplane, and the airplane had crashed and someone was killed (return to the murder theme). "The train," he said, "is safer, and also you go home on the train." In this fantasy he refers to the wish to go home. But he no longer says that he is going to tear the doors down and go home, for this is not acceptable in the group; "father has said you can't go home again," and the group has agreed. Finally, in a delightful bit of schizophrenic humor, he returned to the idea of the sailor suit and said, "We can go home when we all get our sailor suits." (The sailor suit here meant recovery, for when they were separated from the hospital they were separated in uniform; and "going home" had for him a special meaning which we did not yet know.)

The time was now up and I summarized the meeting in terms of loneliness, delinquency, and feelings about going home, speaking of the family constellation, of separation anxiety, and of the loneliness which everyone feels when he leaves home, and tying in the discussion of delinquency with the theme of acceptable behavior and self-control, citing specific examples from the meeting.

In the staff meeting following this community meeting, the nurse reported that during the Red Cross entertainment on the ward the previous night, Smith had become very talkative and, suddenly aware of the inappropriateness of his behavior, had

turned to her and said, "I think I'd better go to bed now." Moved by the manner in which he had spoken to her, she had tucked him into bed. Later, after the ward had all gone to bed, he had come to the nurse's station and said "Good night" to her.

After the Friday meeting the patients who had acted as "therapists" for Smith on consecutive days in the previous week had been transferred to other wards. Three new "psychopath" patients had been admitted.

During the weekend, which had been reasonably quiet, two things had happened on the ward which I was unaware of at the time of the meeting. First, Burton and Eastman had entered into an alliance, dominated by Burton's jealousy of Smith, to refuse to be led into a discussion of childhood. (This "plot" failed, however, because the discussion in the hour came spontaneously so close to things important to members of the group that the desire to get on with it was greater than the desire to destroy it.) Second, Delaney had fulfilled his wish to strike Smith. Unlike Burton's anxiety, which came from jealousy of Smith, Delaney's anxiety came from the fear of insanity which tormented him. His need to strike Smith, I found out in individual interviews with him, was a need to strike down the fear of "crazy" behavior which welled up inside himself; and Smith, by his "crazy" behavior, became the personalized scapegoat of Delaney's aggression against an image of himself.

On Monday, as evidence of their eagerness, the patients assembled quickly and seated themselves closer to me than they had at any of the previous meetings of the group. Smith continued to sit near me at the right side. Delaney sat far away from me to the north, on a bed; and the two other schizophrenics—Burton and Eastman—sat together on my right, but farther away than Smith.

The meeting began with several minutes of silence. Then Smith said, "Can I go home now? I'm well enough to go home. I'm perfectly well." In effect, he was saying, "Let me out." And in this sense he spoke not only for himself but for many of the other patients. Although all of the patients were here involun-

tarily, and they were eager to be out and to escape the stigma of being hospitalized for mental disorder, none of them responded. I, too, was silent. Usually, when an administrative question of this sort was raised persistently in the group, I would ask the patient what his feelings were and/or tell him, "Write your name on the list and I will see you in my office and we will talk about it." But I felt that it would be unwise to do so in this situation because of the strong "favorite son" fantasies which Smith had about me. It was curious, therefore, that after a few minutes of silence, Smith said, "No one else wants to talk. Why don't you and I go into your office and talk?" The "we," which in the Friday meeting had aligned him with the group, was now a "we" of leader and himself. In a way, he was saying, "Since no one is talking, Father, call off the meeting and you and I will go off together."

Ignoring this aspect of his communication, I replied with an interpretation of the silence, "It isn't that no one *wants* to talk; it's that no one *is* talking.

Then, after a prolonged period of silence, I spoke of the fact that people frequently hate to be the first ones to speak in a group, and discussed the implications of this in terms of self-consciousness, shyness, courage, and pressure. It was hoped that this would alleviate their anxiety about breaking the silence. But perhaps my comments only made them even more self-conscious, for none of the other patients replied. Smith was now talking under pressure, but softly. Then he again pleaded, "I'm well enough to go home. I'm perfectly recovered. I'm ready to go out. Doctor, can I sign the papers?" My reply was a firm quiet denial on authority, "I don't think you are well enough." At this, there was laughter in the group and an obvious relief of tension. My reply had apparently given the community the reassurance they sought—namely, that Smith was not "fooling" me, as both the patients and the staff, I learned later, had feared. (This impression that I was unaware of how "crazy" he really was had been created by my telling him that he was "acting" crazy.)

Smith now repeated the story which he had told in the first meeting about the coach who had promised to send him into the game and had then at the last moment changed his mind.

And again he said, "This killed me." (Here, it seems he saw a parallel between his readiness then to go into the game and his readiness now to go home, and I felt that he was asking me, "Can I trust you?") This time, however, the story was not followed by the spate of delusional comments that had accompanied its first telling. Instead, Smith now ventured into an analysis of his difficulty. He spoke of having an "inferiority complex" and of having been "treated badly" as a child.

At this point I repeated my statement, "I do not think you are well enough to leave the hospital." Then I called upon the group for corroboration of my view, "Has anyone in the group any observations that will help Smith appreciate this?" One patient immediately replied, "Yes, he bit me."¹⁹ I made a slight startled gesture of surprise to show Smith my disappointment at his lack of control. "He asked for my hand," the other patient continued, "and I offered it to him, but he bit it. (I did not interpret.) But he apologized and I've forgiven him." Another patient said, "Animals bite." Then Burton attempted to discredit his rival by declaring him "inhuman." He reminded us, "A few days ago he told us himself that he was a gorilla with its tail cut off." (So his rival is not only inhuman, but castrated.) Another patient, taking up the cue, said, "He sits on his rack and barks" and someone added, "Because of the full moon."

Though no one laughed at the joke obviously intended in this last comment, it was impressive that the group had turned to humor rather than anger; and, humor being a socially more acceptable expression of hostility, they had revealed a surprising tolerance of such behavior as biting. One patient who himself very much wanted to get out of the hospital, now said, "If he wants to go out, let him go out." "But," I replied, "he bites." Delaney immediately remarked, "We are never all grown up." Taking this remark as a cue, I said that perhaps this is a fortunate thing, for it means that there is always room to grow and to improve. But if one assumes that he has reached a final point, he will block further growth or improvement. This, I pointed

19. Like the doctor who had provoked Smith's anxiety, the patient whom he bit was a member of a racial minority group. This is significant in relation to Smith's statement about being "a man" on Guam and his description of the natives as his only "friends" there.

out, was what Smith was doing; he had come to the conclusion that he was indeed perfectly well, while he still had lots of room for improvement (i.e., he bites; he is not ready to go out).

At this point I played a record on revenge in which a mother, talking to her little girl, threatens to bite her for having bitten another child.²⁰ This record enabled the patients to laugh at "animal-like behavior," but to direct their laughter away from Smith to the little girl. It also put animal behavior on a par with early childhood behavior. The discussion, which had started slowly, now became very active, and it was necessary to interrupt it to summarize the meeting at the close of the hour.

As I walked out of the room a patient who had not spoken during the meeting said to Smith, "Next time sit with the others." This was disapproval of Smith's sitting with the officer rather than the jealousy which had provoked Burton or the fear of insanity which had disturbed Delaney.

The hour on Tuesday was passed in almost total silence, a silence which probably was attributable mainly to resentment toward Smith. But it was also perhaps related to the fact that 11 of the 25 patients were spending their last day on the ward and in some measure no longer felt themselves a part of it. Smith, who was developing some mild Parkinson-like symptoms from the ataractic drug which he was receiving, again took a chair at my right side. The rest of the patients sat farther away, presumably in protest against the doctor-Smith "closeness." There was considerable obvious tension in the group, but it was under control.

During the meeting Smith again said that he wanted to go home, but he no longer protested that he was well. On one occasion he asked to be excused to go to the head, and I nodded but made no comment. On another occasion he raised the question of where he would go from this ward; this time I replied

20. This was done to "regress" their fantasies to an earlier time when biting had its greatest meaning. Also it was an effort to open the discussion to a wider range of patients. Records were used frequently in this series of meetings since it was felt that we needed all of the devices available to keep the community in focus and take the limelight from the narcissistic infantile schizophrenic patient, a limelight which alienated him from the group and engendered their intense hostility.

as I conventionally did to specific administrative questions of this type: "We will talk about these things in my office if you will write your name on the list on the bulletin board." He apologized for bringing the matter up in the meeting, and later did write his name on the list for the first time. His bizarre behavior was at last under control, probably partly from the medication and partly from the effect of the community, and he did not carry on any prolonged conversations with me.

One of the new factors in the group situation now was the presence on the ward of a new patient, another very sick schizophrenic, Navaro, who was argumentative, hostile, extremely jealous, and rivalrous for domination of the group and for attention from the doctor. This patient sat directly across from Smith, grimacing at him and trying to precipitate a reaction, but Smith made no response to this provocation.

The meeting was summarized in terms of the silence, of how unusual it is for a group of people to sit for a prolonged period of time without talking. "There are many explanations for silence," I said; "I won't attempt to explain this one for it would simply be a guess on my part. The time is yours to use as you wish." My summary served several purposes. First, it denied that I had any omnipotence or clairvoyant powers; second, it described what had happened and stated that this was unusual; and, finally, it implied that the time had indeed been used, though perhaps in a curious way.

In the following staff meeting the corpsman told me that Smith had walked up and down the ward the previous night telling the group that his body was invisible and that he could walk through a wall. The patients tried to egg him on to walking through the walls of the ward and escaping, as he wanted to. It was interesting that the delusions now were not revealed in the community meeting, but on the ward, and that the patient's behavior was socially improved in the meetings as evidenced by his no longer protesting that he was well, his apology to me, and his fulfilling of the social requirements for seeing me by writing his name on the list.

When the Wednesday meeting opened, Smith was again in

the position which he now regularly occupied, next to me on the right, and the other patients were again at a distance. The meeting began with my introduction of a visitor, a psychologist who had come to observe. Following this, several patients spoke with reference to the records that had been played in previous meetings. This seemed to be in the nature of an appeal for me to bring something again into the meetings for them to talk about. Burton said, "The patients are silent in the meetings because they don't want to talk about their personal problems. The records are helpful." The implication was clear: he was reluctant to talk about his own problems and was frightened when others did so.

During this meeting, Smith's behavior indicated obvious resentment toward me, perhaps for my letting into the "charmed circle" other siblings, Navaro, and particularly Burton, with whom an extremely hostile jealous relationship had developed. Navaro, who had allied himself with Burton, now said, "I felt all right until I saw the movie about the jungle on TV last night." This remark was intended as some sort of provocation of Smith, and Smith responded to it with the same gesture of contempt that he had made several times previously to the group which rejected him—he began speaking in the schizophrenic gibberish he called "Japanese." Burton mocked the mock-Japanese and said, "How do you imitate animals?" Smith performed, making animal sounds. To taunt and ridicule him further, Burton ordered, "Show them how you walk." Smith walked a few stumbling steps and fell to the floor. Burton pronounced, "It's an act." I interrupted to explain that Smith's difficulty in walking was due to the medicine that he was being given (i.e., that he was sick), and the visiting psychologist asked Burton, "Why is it that an 'act' is so upsetting to you?"

Burton made no reply, and a number of patients now returned to the discussion of the records. "They can talk about childhood," one of the patients said. Then another patient, referring to the dialogue between the mother and child that had been played on the previous day, observed: "It sounds strange sitting on a ward and hearing this record, knowing this really happened. . . . I was lost as a child." (The fact that the child in the record was

lost from her mother at the time she bit the other child was quite incidental, but to this patient it was the impressive point in the situation which the record presented. It is interesting, also, that he saw the episode as something that had really happened, rather than as an imagined experience.)

Now a number of other patients told childhood experiences of being lost, and Smith said, "I was lost once and my parents found me." I reflected aloud on the many things that the words "being lost" mean, and suggested several possibilities.

Then Navaro said, "There are lots of *sick doctors*," a projection, but a clue, and occasionally true in reality like so many paranoid ideas. At this point, a recently admitted officer-patient said angrily, "The doctors lied to me. They didn't tell me I was going to a psychiatric ward. They said I was going to 'the hospital' and now I'm locked up." He was deeply resentful of this, and with justification.

Navaro broke in with a highly paradoxical statement, "I'm not sick. When I get drunk I am sick and I want to murder people." I commented, "That doesn't sound normal." He replied, trying to change the direction away from himself, "I get a charge out of Smith's behavior," and then he laughed in a silly way. The immediate association of his two statements suggested that perhaps Smith was one of the persons he wanted to murder. But the reference to Smith was also a display of his sadism; he was trying to engineer a fight between Burton and Smith. Another patient, visibly shaken and tremulous, now returned to the reference to "sick doctors." He told about the doctors who had treated him when he had a broken arm. "They would just come and look at me and not say a word. They just laughed at me." The old retired chief who had made the comment about sailor suits said, "It's no good to talk to doctors, they're all sick." (This view, based upon the chief's prolonged confinement in a state hospital in what he felt was an "unjust incarceration," was partial explanation of his silence in the meetings.)

The patients here were displacing on "sick doctors" the hostility which they felt toward me. Smith apparently sensed this, for first he came to the defense of doctors, and then as evidence of his ambivalence he countered, "I want to be a doctor.

Can I be a doctor?" All the while he acted like a silly caricature of a psychiatrist. Perhaps with some wish to please me, he was identifying himself with me and thus taking the hostility of the group upon himself. (The sibling rivalry and ambivalence to doctors was conceived of in its basic relatedness to their father images and myself as a father surrogate at this time.) The group tension mounted significantly at this point, Burton shouting angrily to me, "Make him shut up." I said nothing, for this was an inappropriate demand, and Smith taunted Burton, "*You* make me shut up." They both stood up with clenched fists and Burton struck Smith.

I arose and separated them and, after they had resumed their seats, I discussed the situation, briefly reviewing Smith's behavior on the ward from the beginning—the things he had said and the bizarre things he had done—as evidence of his feeling that in a sense he did not belong to the group, though he wanted to belong. This probably explained why he had separated himself from the group and moved to sit near me, I said. (This was the only time that a patient's choice of seat was ever specifically discussed in a community meeting.) I added that both he and other patients had been inciting each other to "unworthy" behavior.

Navaro, who had egged on the fight, now expressed sympathy for Smith, saying that he knew how he would have felt if he had been in Smith's place. The visiting psychologist said to Burton, "Perhaps if the peculiar behavior, such as falling to the deck, *was necessary*, you might not feel upset by it." Burton, a tough Marine, replied with a confession, "Two times recently I have cried in the meeting." Now he has told the group partly why he feels that the patients should be silent and not talk about their personal problems. To support him, I said, "We didn't think you were putting on an act." But Burton, frightened by momentarily letting down his guard, made a menacing gesture toward Smith, and the fight threatened to break out again.

At this point I issued a command to Smith, "Sit down!"

"I can't control myself," he countered.

"I think you have more control over yourself than you think you do."

He sat, and since the time was up I summarized the meeting, saying, "Perhaps there is some resentment about yesterday's silence—the doctor who came and looked and did not say a word; you must have been uncomfortable yesterday when I did not talk." There were nods of agreement.

As the group was disbanding, Burton shook hands with Smith and apologized, then asked to see me in my office, where a brief discussion of his own ambivalent feelings toward me and his hostility toward Smith relieved his anxiety.

The Thursday meeting had made it clear that the fantasy of several staff members that Smith's social problem as "the favorite son" rejected by the siblings was not far from the consciousness of the group. In the Friday meeting Smith himself brought it explicitly into the open.

The patients gathered very slowly for the Friday meeting, and formed an entirely different seating pattern from the previous ones. No one sat across from me; the patients lined to the left and to the right, with their chairs pulled back between their beds in a sort of withdrawal from me. Yet, in terms of distance, they were closer than they had been for several days.

Smith walked slowly into the room after the meeting had begun and sat at my right side, very close, for the fourth consecutive day. He took a chair that was directly between Burton, who sat the second closest to me, and me. With the group still silent, I moved my chair slightly forward so I could see Burton. He was looking at the wall, nonchalantly disregarding the situation.

The meeting began in silence, and after 10 minutes I asked, "I wonder what the silence means?" This brought a response from Smith: "I am feeling better. I wonder why they don't talk too." Then he pleaded with the other patients to talk. He was again taking the doctor's role, identifying himself with me even more strongly than he had yesterday.

There was another long silence and, since the meeting had a dream-like quality, to try to get things going I employed a technique that occurred to me at the moment: "I saw a patient yesterday, somewhere else, who told me he had a dream, and in

the dream nothing happened, and it was all silent." The patients had been given a blank screen. Smith reacted at once, "I had a dream last night. I was in Guam. It was about a crazy enlisted man and a Negro first class. Negroes think themselves superior—I mean inferior—though they are all equal and all the same blood. The crazy sailor was promoted to chief."

He had given us a dream which was alleged to have occurred last night, though it was conceivably produced on the spot; and in this dream he returned to Guam to master his conflict. The pun on "first class" suggested his ambivalent feelings about Negroes. By a slip of the tongue he refers to them as thinking themselves superior, though his own thinking is that they are equal; but his dream does not show equality, for it shows the crazy sailor being promoted to chief, one rate above first class. In the dream the crazy man turns out to be not crazy at all, or crazy like a fox; or at least his craziness did not hinder his being promoted among his enemies, who are pictured in the dream in some deprecatory, ambivalent reference to first class Negroes.

I made no comment on the dream other than to repeat his last two words: "To chief?" Smith then, surprisingly, for nothing had been said about wishes, commented, "Perhaps that was his [my] wish." One interpretation of the dream had been correctly made by the patient, and he now turned to me and said, "Do you have any questions about the dream?" I said, "No." It would have been impossible to interpret the dream without knowing more about his associations. Moreover, in view of his domination of the group and his wish to have the doctor for himself, it would probably have been unwise to pay too much attention to this production at this time.

Following my silence, Smith tried to provoke Navaro, who was sitting directly across from him, as yesterday he had provoked him, who had in turn provoked Burton, who had in turn struck Smith in a sort of chain reaction. Today Navaro was unmoved; he sat hallucinating, laughing and talking quietly to himself in a hebephrenic fashion. Frustrated by his failure to arouse a response from the group as a whole, from me, and from Navaro,

Smith reverted to the psuedo-Japanese,²¹ both as a gesture of contempt for the group and also as a desperate attempt to talk to the others in some language, searching for some way to communicate. He then went from this schizophrenic gibberish into abracadabra and magic talk.

"There is voodoo on the ward," he said. "It is cold here. I am dead. I am going to be president; to be a doctor; a rich Indian fighter."

From the magical schizophrenic talk he has gone step by step to the feeling of cold, or desertion (which is what it really was about); and to lack warmth, affection, and response is the same as being dead. We can see the social development of this delusion in his rejection by the group; and for the first time in many days he has confessed a delusion in the meeting itself: he is dead. He makes the paradoxical statement that he is going to be president, to be a doctor, and a rich Indian fighter. These grandiose statements were elaborated upon in what seems a conscious attempt to provoke a response. Having been unable to provoke words or to provoke anger, he now attempts to provoke the affect of laughter, directed at himself. Perhaps they will laugh at him.²² And they do; Navaro and a new patient, both schizophrenic, laugh.

The nature of these delusions is not unlike those he first revealed: to be president is to be a giant, the greatest power in the land, the strongest man; to be a doctor is to be the greatest power, the strongest man in the room; to be a rich Indian fighter is to be a powerful type of individual in a minority racial group, such as the group that had been a nuclear part of Smith's life at the time of his schizophrenic break. But again, as in the dream of the first class Negro, his ambivalent feelings are revealed, for his warm feelings for Negroes with whom he identified were also evident; this Indian is a "rich" Indian. (The fact that he is a fighter could be an echo of yesterday's fight with Burton.)

Now all of these comments, following his failure to provoke

21. He had told the corpsman that this "Japanese" was really "Negro talk."

22. This perhaps would mean that after all silent people were not inanimate things, statues, or dead zombies, and with any human affect response there would be evidence that they were not dead; and if so, perhaps he too was alive.

the group into communication, can be conceived of as associations to the dream. If this is the case, he had stated in a different way the wish which was implied in his first comments about the dream: a wish for power by way of father surrogates (i.e., president and doctor) and the masculine power of the aggressive, successful minority.

Aware that he was trying to tell the group something but that neither the group nor he would accept this as an interpretation of the dream, I focused attention on the *nature of the messages*: "You are making up a fantastic story. You do have something to tell us about yourself. You should, but this isn't it."

This interpretation labeled his message as daydream. It said, "Daydream is saying something important, but we cannot understand it in daydream. Translate it or try again." Feeling a mild reprimand, Smith replied immediately, "I'm sorry." But soon he returned to the dream, speaking of religious preoccupations and of the crazy Negro, and at last he interpreted it as meaning to him, "If a person believes in God he is well" (a person being himself).

Again the group was silent in some sort of restitution for yesterday, when too much participation had ended with "violence." But they were attentive, as if they were saying, "We will watch and see what happens." If the interpretation of the dream is "Believe in God, one is well," one might say that to believe in father or to have father is to make one complete, for completeness to Smith now means a return to sanity. His interpretation is a tacit admission of the not-well state and a wish.

At this point, because of the unusual circumstances of the group and the lack of participation, I made an unusual type of interpretation. "I wonder if some of the feelings in the group are caused by your sitting next to me?" This was immediately taken up by Smith, who said, "Do you think I should move?" and started to rise. I turned to the group and said, "I wonder what the others think?"

Of course Smith knew what the others thought. They had told him, both during and after the meetings, in many ways. My question was, however, an attempt both to direct the group meeting away from Smith and to bring the others in—to fulfill

his wish that they would not reject him and make him feel dead (or, like the coach, "kill him"). But no one spoke. The failure of patients to speak is not necessarily to be interpreted as "resistance" (though of course it sometimes is). When, so far as the leader is concerned, there is no evident need for them to communicate anything, their silence may be a form of self-control and, as such, is welcome. To sit silently, attentively, cooperating in many nonverbal ways, is not without its merit.

However, Smith had asked a question and should be answered. The patients would not answer, so I answered both for myself and for them: "Patients sit where they want to." (In answers of this sort it is very important to use a minimum of words, for elaboration of such ideas should not come from the leader, but from the group.)

At this point Smith made the penetrating interpretation: "I wonder if they think I am the favorite son?"

This had a profound effect on the group. Though no one spoke, they were perceptibly affected. He had certainly stated what the staff had been saying in their meetings for three days. It was his fantasy as well as ours, and of course the desire to be the favorite son had much to do with his religious preoccupations and with the jealousy, the triangles which he had set up or which had occurred around him, and the dream of the rise to "championship"; and it was also what he was thinking, projected in a question as if it were what "they" were thinking. It is to be noted that this followed immediately after an interpretation, filling the blank by what he interpreted as a "kind comment," for I had tacitly permitted him to be the favorite son, and as a matter of fact he sat down as he began his interpretation.

The group remained silent, and again he reverted to pseudo-Japanese, both because of his frustration and because of his desire to taunt the others into talking. But, suddenly checking himself in midair he said, "I shouldn't be talking crazy."²³ This was a self-corrective phenomenon to which the group had contributed by nonverbal messages. The pseudo-Japanese was addressed to the group; and he would probably have reverted into

²³. Just as he had ended his first meeting by saying, "I shouldn't be talking like this."

delusional material if the community had not been the assembled moderating audience.

The hour was now up, and I summarized it in terms of dreams, wishes, and wish fulfillment.

The Friday hour will be touched upon very briefly to conclude the report on this series of meetings with what happened after the favorite son interpretation. There were nine new patients in the group on Friday, and, after a period of silence, one of these opened the discussion by asking, "What are these meetings for?" No one replied. We were starting all over again. Then Navaro spoke, "I am physically sick. I want medicine," denying his mental illness, and he elaborated upon this idea.

While he was speaking Smith made some vague comments about a fight; there had apparently been a pushing encounter between Navaro and him in the lavatory the night before. Then he began to provoke Navaro by gestures and mimicry, and Navaro responded by acting in a bizarre manner. The old chief, who played the role of the comic, making at appropriate moments brief but pertinent comments, said to Navaro, "But you are crazy." The remark did not have an immediately discernible impact on the patient, but it did on the others.

Then the question with which the meeting had opened was answered by another new patient in his first meeting, "The meetings are held to find out whether you are crazy or not." He had interpreted them in the light of the context of his first meeting.

There was another period of silence, and Navaro belatedly admitted, "I am crazy."

Smith replied, "The trouble with you is that you're jealous." (Smith was probably speaking about himself, and he was aware of his jealousy. He felt that he had the doctor, and Navaro felt that he had the group. Smith was aware of a latent homosexual problem, but it seems doubtful that Navaro was.) At this there was a roar of laughter from the group, and I immediately asked, "Why did you laugh at the word 'jealous'?" There was silence.

Undoubtedly the laughter was partly at Smith, because they all perceived that jealousy was his problem, but it was also the

delayed release of the tension which had been built up since the chief had said, "But you are crazy." References in the meetings to the word "crazy" were usually made much more vaguely than this—for example, one patient would say, "Crazy people are in psychiatric wards," and another would reply, "Well?" They could all laugh at this. But direct confrontation was nothing to laugh at. It was only with the word "jealousy"—used as the cause of his trouble, i.e., "crazy"—that the group could release the tension within them. The new patient now repeated, "What is this? What are we doing?" He was not satisfied with the explanation that they were meeting to find out whether they were crazy. This was discussed by the group for a while, and Navaro, in justification of his own "strength," stated, "I tell everybody what they ought to do."

Smith, turning to him, began sputteringly, "You . . . you . . . you go to . . ." Then, in an interesting correction of himself in stride, he said, "I oughtn't to tell you what to do." In a sense this was a clarification of his role in the group and his own separation of self from the group, his finding of his own identity. In the first meeting he had said he shouldn't be talking about his brother for fear he would be thrown in the brig, and he had ended the last meeting by saying that he shouldn't talk in the pseudo-Japanese jargon; but now he is talking about what he should not do in terms of social relationships. Towards the end of the meeting Smith used the word "friends," and I summarized the meeting in terms of friendship, friendliness, and the feelings between people. Thus we see that, on the last day of the week, Smith is getting along satisfactorily, though like Thursday's child, he has a long way to go.

The following Monday was Smith's last day on the ward. He maintained, "I am feeling good, Doctor," and manifested great self-control at the Monday meeting. Navaro did not sit across from him, and there was little mimicry between them. The overt hostility had ended.

CHAPTER IX

FURTHER EXAMPLES OF COMMUNITY MEETINGS ON OFFICERS AND MEN

The following meetings were focused particularly on an officer, Lieutenant Brewster, who was suffering from a moderately severe paranoid schizophrenic reaction. But a secondary drama was also played out around a highly delusional enlisted man named Jones.

On Monday, the first day of this series, there were 27 patients on the ward. When I came in to start the meeting, many of them had already drawn their chairs into position, indicating some eagerness to get on with the business of the day. But Jones, a new patient who had been admitted over the weekend, had refused to join the group because, as he told the nurse, "I know all about these meetings. They're Communist meetings." He was sitting alone at the far end of the ward by the radio. Though I persuaded him to join us, he sat in total silence throughout this first hour.

I had hardly taken my chair when Brewster, who had also been admitted over the weekend, and sat directly opposite me in the "guest-of-honor chair," asked, "Is it all right if I speak about how I feel?" I assured him that it was, and he began, as if giving an after-dinner speech: "I am reminded of a joke about Groucho Marx. An 80-year-old man, describing his life to Groucho, said, 'I play tennis and I have never drunk or smoked. That's living.' And Groucho replied, 'That's all you can say for it.'"

No one laughed, and after a slight pause he continued self-importantly, "I am Lieutenant Brewster. I want to go ashore and I want to have a drink." Again a pause, and again no laughter.

Trying once more, he said, "When I was sent to Cellblock 41 at _____ Hospital (laughter from many in the group), I was

hauled by four corpsmen to the quiet room." . . . "When I turned in on the sick list, the doctor said, 'Bub,'—while we were drinking tea and eating together we got to be good friends—'Lieutenant,' he said, 'I'm sorry about you going to ----- Hospital.' " Then he told us that when he had asked for writing paper at ----- Hospital the nurse there had said to him, "Your rank won't do anything for you here."

I had not yet had an individual interview with Brewster, for he had been admitted only the night before from overseas (in restraints and sedated). But from these opening communications to the group a number of inferences could be drawn. The nature of his joke, ridiculing the impotent old man, and his boast of his own physical prowess (it took four corpsmen to cope with him) suggested a conflict about his strength and size having its roots in infancy and early childhood. His deep concern with status was shown both in his announcement of his own officer status (by implication giving himself a slightly higher rank than he actually held) and in his account of himself hobnobbing with "important" people, by which he was impressing upon the other patients that he was more powerful than they by virtue of his officer status. Yet he also revealed an ambivalence and conflict about his present status in the incident which he told about the nurse and in the extremely ambivalent image of himself—powerful-powerless—which he presented.

His conflict with authority and his search for a good father seemed apparent, and his reiteration of the theme of his own status, his own self-improvement, and his own authority suggested a deep wish to displace a punitive father.²⁴

So far the only response which Brewster's communications had elicited from the group had been laughter when he ridiculed the previous hospital, displacing his derision upon the hospital by the use of the word "cellblock." Since no one had picked up his cues, he began to repeat his boast of physical prowess, now in the form of a threat, "If I get upset, it'll take four corpsmen to

24. In a later interview with the patient, I was told that his father, an unskilled laborer, was alcoholic, domineering, and often brutally cruel to the patient as a child, beating him mercilessly. "I was scared to death of my father and had fears at night," he told me. It is interesting also, in the light of the patient's repeated references to "four" corpsmen, that he had four siblings, all brothers.

drag me to the quiet room." He laughed as he said this. Then he announced, "I am an officer and a gentleman." He went on to tell how on occasions he "ran the ship," and how he got "chewed out" in the captain's quarters over the "green cloth," and how he was a graduate of college and a friend of a college professor, and how he had several times been a counsel for enlisted men at court martial.

To this he got a response: at the mention of "court martial," another paranoid schizophrenic patient named Euler, who was in disciplinary status and who was literally shaking because of his fear and hatred of authority, interrupted this long, boastful harangue, "Why do you call officers gentlemen?"

Brewster, somewhat taken aback, modified it, "They aren't all gentlemen."

"No," Euler pronounced with clenched fists, "They're rats—nine out of ten of them are rats."

The court martial had set Euler off. He could not endure the thought of this intolerable "father figure" speaking for him. But he had chosen to draw the line of attack on the question of "officers and gentlemen."

Brewster, in an attempt to identify himself with the enlisted men to elicit their sympathy, now told how he had come up through the ranks. (In a sense, of course, this was also a reaffirmation of his potency, and also evidence that he was more potent than they.) But the angry exchange continued.

I brought the problem into focus in the following way, "It seems you are dealing with a very important emotional subject, and you are talking in generalities. What is a gentleman? Perhaps we can get a clear definition to help clarify this."

Euler replied at once, "A gentleman is a man who treats you squarely and like a human being."

"Perhaps you could tell us specifically about your feelings about officers," I proposed. There was a pause, and I added, "Something that happened?" My question immediately meant to Euler something which he had previously communicated to me in an interview.

"You mean the court martial?"

"Go ahead."

Euler then told about the experience which had precipitated him into the discussion—how a high ranking officer at his station had treated him like a gentleman, even complimenting him on his class standing, and had then given him a summary court martial for being thirteen miles out of bounds. He went on from this into a tirade against officers, ending with, "Officers and enlisted men are kept apart." Brewster, flaunting his status in Euler's face, asked, "Why do you think they do that?" Euler replied, "To avoid riots."

I interrupted: "We have had many officers on this ward; we never have riots." Euler replied, "It's different here," and then he returned to his tirade against officers. I asked him, "Do you feel that way about me?" "No, sir," he replied, "You're a doctor, sir."

At this point another patient—a chief warrant officer who was only moderately ill with a neurotic disorder—spoke very movingly of his feelings as a career Naval officer who had come up from the ranks. Some officers, he acknowledged, did wrong things; he was on a duty station where an officer was under investigation. "But," he believed, "most everybody here tries to be a gentleman." He added, making it clear that he meant the enlisted men too, "It isn't just officers." For himself, he went on, he was thankful for the "rest" that he was getting in the hospital, and he felt friendly and grateful toward the doctors, nurses, and corpsmen.

Immediately after he had finished speaking, Euler said sincerely, "Thank you," and several other patients, obviously moved, expressed appreciation.

The chief warrant officer had brought to an end the search for a definition of the word "gentleman" by, in effect, pointing by way of examples to themselves. He had also averted the collision which had seemed imminent. I saw in Euler's immediate "Thank you" both an expression of courtesy to the chief warrant officer as gentleman—the good father symbol and benevolent authority—and an expression of contempt for the lieutenant as officer—the symbol of bad father and rigid authority. The others who had joined their appreciation to his were, I felt, expressing relief that the issue had been brought to a close. They

must also have taken comfort, I thought, from his describing the mental hospital as a place in which to "rest," for it fitted in with their wish to deny their mental illness.

At this point Brewster, attempting to share in the group approval, identified with the chief warrant officer: "That's exactly how I feel, too." Then, following out his own problem in terms of identification now, rather than attack, he spoke of his unhappiness in childhood and college and of the things he could not have. "I grew up with an inferiority complex because my parents were foreign born and spoke with an accent," he said. At this, another patient of foreign extraction swore quietly.

The time was now drawing to a close and I wanted some clarification on the experience in Cellblock 41 at ----- Hospital before the conclusion of the meeting. I asked whether he would like to talk about this experience.

He accepted with some relish. "They were trying to drive me insane," he told us. "I was placed in the quiet room and given injections of sodium amyntal. I was put in the 'cell' because I was shouting on the ward. In the 'cell,'—that was the first time I ever got down and prayed." He told how he had beaten against the door of the quiet room, and how on the second night he had shouted to a corpsman who came by, "Don't come in by yourself—I might kill you. You'd better get four corpsmen." So four corpsmen came and held him down while he received a barbital injection. As he described the episode, he seemed to be saying that he had almost invited the use of the quiet room and the medication. Certainly he had dared the corpsmen to seclude him by his threats of aggression, perhaps inviting the seclusion room and then inviting an escape by sleep with the drugs, and freeing himself from guilt by the "necessary" force and needle.

When he had finished telling this, a patient named Richards, who had not previously spoken, said to him thoughtfully, "If you went back to the service now, would you treat your men differently?" Brewster replied, "No. I carry out my orders." I asked Richards, "Did you have something else in mind?" He paused and then said, "Yes, I wouldn't want to serve under him."

Brewster now returned to comments about college. In the midst of them a corpsman put a penetrating question to him,

"You said you did poorly the first semester in college, and then did well. Why was there a change?" We were never to know what actually happened at that moment in college, but we can assume that it was something very meaningful for it was denied and repressed and sloughed off in Brewster's mock-deferential reply, "There are psychologists here who can answer that."

He began talking about it in a garbled, unintelligible fashion. Here I commanded, "Be specific." When he attempted to follow my command but was unable to unravel the story, I became more specific. "Were you ever afraid?" I asked, careful not to indicate time or place.

"Yes," he replied. "When I had a hernia operation I screamed when they held me and tied me down. I am very strong. I am very strong. I don't want to kill anyone here."

Perhaps this was a clue to the meaning of the quiet room to him. In a quick staccato sequence he tells that he was held down, that he had an operation in the inguinal region, and twice he asserts his own potency, "I am very strong. I am very strong." (In the present tense.) Now the impotency conflict, the aggression, and the fears of bodily injury while asleep or held powerless are suggested, and his real feelings in relation to others in hospitals are exposed in the statement, "I don't want to kill anyone here," a denial of his early murderous fantasies toward his cruel father and his feelings perhaps toward anyone who would hold him down and harm his body. The fear of death here is very real, and so also are the sexual implications.²⁵

At this point the discussion turned to the fear of being hurt and the desire to hurt, or the controlled impulse to hurt, and Brewster now told a short story, "One day when I was aboard a tin can (destroyer), I was on deck and I was scared. We were in collision position, headed for a carrier. I didn't know what to do, but I did something because I had to. I changed the course

25. The operation is not presumed as being specifically pathogenic in this man's illness, but his communications here certainly confirm the earlier inference as to his castration fears. The fact that this aspect of his problem is not dealt with directly leads in some degree to the repression of the deeper anxiety-provoking factors in this patient's illness; and the reason why the direct approach has not been taken in this rapidly changing group can best be explained by two very simple aphorisms: (1) If you can't help, don't harm; and (2) Don't raise more dust than you can settle.

to sharp port and rang the alarm so the captain came running. We narrowly missed a collision."

This story, of course, has many implications. One is that the patient, in a moment of crisis, had acted to save his little ship, which the big ship would surely have demolished if the two had collided—he was the "hero" of the moment. "I didn't know what to do, but I did something because I had to." The story thus reinforces the inference that the potency-impotency conflict was the deep, essential issue here and that it was directly related to Brewster's feelings about status, for he had momentarily supplanted and "saved" the captain, his reputation, his ship and crew, and its most important member—himself.

There was no need, I felt, to discuss this aspect of Brewster's communications with the group. Instead, I said, "Isn't this story a lot like this hour? You are in collision position here too, coming head-on with another patient. Everyone deals with such situations in his own way. We draw on whatever experience we have. In the situation you have told us about, a collision was avoided by a combination of circumstances: judgment, sound heads, and the 'skipper's' intervention."

Both Brewster and Euler seemed struck by the analogy. There was hush in the ward. Finally Brewster said softly, "I don't want to monopolize the meeting." (This comment, of course, is a denial, for he had meant to do precisely that.)

Our time was now up, and in summarizing the hour I pointed out that Brewster had felt the need to tell us something about himself so that we would understand him and the importance of status to him. "He has told us about his childhood experiences and his fears, with many references to status, and has touched upon questions of superiority and inferiority. Some of his comments made the group feel uncomfortable and antagonistic, and that is the reason why we were all relieved by the chief warrant officer's remarks on officers and gentlemen. And finally, we have ended the discussion with a story which more or less illustrates what has happened here with us during the hour."

The meeting reported here has been looked at almost as if it were an analytic hour with Brewster, in which he has brought to light a conflict in relationship to the status situation in which

he finds himself at this time. But it must be borne in mind that other things were happening in regard to almost all the other patients also, and some of these were obvious in their verbalizations. Most striking, perhaps, was the fact that Euler's tremor disappeared after his outburst; it was never again observed during a meeting, although it was still apparent in his interviews with me. It must also be remembered that it was the pressure of the group, and only indirectly the leader, that led Brewster back, step by step, to the traumatic psychological experience of the hernia operation. As the most verbal member of the group, he permitted the greatest understanding of his individual conflict and made the greatest use of the group in therapy.²⁶

Throughout the next meeting it was obvious that Euler's symptomatic tremor had not returned; however, he did not speak today. It was very frequently observed that when someone had spoken angrily on one day, he was silent the next day.²⁷

The meeting began, as Yesterday's had, with a question from Brewster, addressed to me, "How are you this morning?" This

26. Following the meeting I saw Brewster in an interview and found him pleasant and cooperative, though it was obvious that he had suspicions and hostility towards all authority. I learned that when he was in the quiet room in the hospital in transit he had literally thought of himself as a prisoner in a cell. Moreover, he was frightened by the narrowness of the confines, which reawakened an early claustrophobia. He began pacing the room to measure the space repeatedly, fearing it would grow smaller and he would be crushed. Finally having driven those attending him to the traditional use of sedation and the seclusion room, his fear and belief that he was going crazy was affirmed and then came his alarm that he would become violent and kill someone; the someone would be a corpsman who came alone in the quiet room, but not if he came in a group of four. He was asking for restraint and asking for the corpsmen to "overpower" him; that he did not resist and that he lay quietly on the floor while he was given an injection of sodium amytal has implications, further confirmed by the statement, "The more I talk the more I get knocked up" (sic); and the more he talked in the quiet room and beat on the wall, the more he was held down and "given the business."

It is also significant that on the ward after the meeting he began to take the mother's or the nurse's role with the patients—being, however, meddlesome by running and over solicitous care, keeping the corpsmen away if he could, bathing those who soiled themselves, and then saying, "I am a two-time loser, and have lost all self-respect." This particular comment he made to me in a requested interview. He was trying desperately to recoup and to regain his self-respect, which in the meeting itself had been discussed in terms of status, for which exhibit A was his commission as officer and gentleman.

sort of semi-joking reversal of roles was quietly ignored. Unashamed, he went on, "The spaghetti was good last night," and several patients agreed with him. He then joked about the hospital: "No liberty . . . Ha ha ha!" No one joined in his laughter.

There was a silence of several minutes, which was broken by Richards, the patient who had yesterday said that he would not want to serve under Brewster: "There's something I'd like to say," he began. "Why it is that I feel so comfortable in this hospital and not in others? When the doctor walks on the ward everyone perks up. A good doctor treats people, sees them, and wants to help them. I've seen some doctors who aren't worth anything."

I asked, "What hospital are you thinking of?"

He named the hospital which Brewster had spoken of yesterday in telling about his quiet room experience. Several of the patients had been in that hospital together, and they vividly described the use of restraints and told about the loss of self-respect that one suffers in being tied up. The gist of the discussion can be summarized in Richards' concluding comment: "They don't treat people with human dignity."

27. In an interview with me after the meeting Euler said that he had "felt terrible since the meeting." When I pointed out that it was good he could talk out and say how he felt, he replied, "Yes, it's the first time in three years, though what really shook me was this: After the meeting the Lieutenant and I were getting along pretty well and talking together, and there wasn't any particular anger. It was sort of a friendly talk, and a corpsman came up and butted in and said, 'Remember, he's a white hat, and you're an enlisted man and let's keep it that way.' He tried to separate us, and then I really got shook, and I tried once later to talk to the Lieutenant but I can't . . . I won't talk to him."

What was accomplished for Euler in the meeting was largely undone by the insensitive behavior of this corpsman. To Euler, it meant that the corpsman was afraid they would fight, and it reactivated the same fear in him. The fact that his tremor was still absent, however, showed that what had been accomplished in the meeting had not been altogether undone. This was later discussed with the corpsman in the learning-on-the-job process. It was my feeling that his action was motivated not only by fear of a fight, but by an unconscious wish for one.

Another patient who requested to see me in the afternoon, one who had been silent during the meeting, said, "I just sat taking it all in. I didn't say anything in the group, but I was thinking that some of the things the officer said were right but that he was 'stuck on himself.' I worked at the swimming pool and some of the officers are gentlemen and some are not. I was struck by what he said about officers, that he didn't say *all* officers were gentlemen, he said that *he* was. Now officers, that he didn't say *all* officers were gentlemen, he said that *he* was. Now what struck me as strange is this: Why should a gentleman announce that he is a gentleman?"

At this point Brewster broke in, "Yes, but I feel some lack of dignity here. I can't have matches. I can't play ping pong when I want to. I can't get out when I want to."

"Are matches and ping pong so important?" I asked him.

"No, but it makes me angry," he replied. Then he launched into a second sea story as an analogy: "Once I was on deck, and we were refueling at sea. The chief said, 'Mr. Brewster, you're in the damn way.' I thought of putting him on report; not that he was wrong, but I didn't want to take all that in front of a lot of white hats. But I ended up doing nothing, because when you refuel at sea someone might get his hand cut off in the tossing of the ship."²⁸

"Again you tell us a story," I reminded him, "that has some bearing on the situation here, about being criticized and not being able to do what you would like to. Without replying to me, he went over to the chief warrant officer (who was of lower rank than he) and knelt before him to light his cigarette from the warrant officer's cigarette.

There was silence for a few minutes and Jones, the schizophrenic who had yesterday been reluctant to join our "Communist meeting," now spoke for the first time in the group, "I don't think you should pry into people's lives in groups . . . It makes you feel uncomfortable." I asked, "Why is that?" and he answered, "It has something to do with Communism and classified information."

But we were not, for the moment, to pursue Jones' uneasiness about exposing the "classified information" of one's life in public, for Richards himself turned the discussion to a related subject, by a personal interpretation of the lieutenant's story: "A father should explain things to his child if he expects good behavior." Brewster took issue with him, "Maybe he can't. If the boy would ask why the stars came out, what would you say?" Richards objected, "That's off the subject." "No," the lieutenant said; "I've had courses in astronomy." (Laughter) Richards

28. In this story he has again verbalized his castration fears in a displaced fashion and has revealed his feelings of inferiority in the fact that it was not in his "power" to put the chief on report or to disobey the chief's implied order to get out of the way.

asked him, "What would you have said?" and Brewster, who had been flaunting his academic superiority, was speechless. "Well,---" A schizophrenic patient who had not spoken in the group before rounded out this flight into astronomy by dreamily murmuring, "The stars are out all the time."

After this there was a short silence, and then Brewster announced, "I am an officer and a man (sic). I don't like to be treated as a boy. I am a man. At 17 I was doing a man's work." Richards dismissed this with a terse comment, "Lots of people do." Brewster repeated again, "I am an officer and a man."

There was silence and a heretofore mute catatonic schizophrenic who had been on the ward for 10 days and had never once spoken a word in all that time, stood up, walked across the room, faced Brewster squarely, and quietly and without expression made a judgment: "*Over-rated.*" Then he returned to his chair and sat down, resuming his monumental silence. There was a burst of laughter from the group.

I had felt somewhat uncomfortable in this meeting because of the very obviously friendly and warm feelings that a number of the patients had expressed about me and about the hospital and the staff. I was uncomfortable, as if they shouldn't say these things. It was my opinion that the pressure of this group forestalled analysis of these transference and counter-transference feelings. Perhaps something of this feeling was communicated to them by the mildly dramatic way in which I had questioned their surprise at the fact that sedation and restraints were not used on our ward. So I summarized the hour in terms of one's right to expect dignified human treatment: "Why should a patient be surprised at being treated with consideration and at the doctor and staff wanting to help him? Isn't this the function of a hospital?"

The Wednesday hour was an exciting and intense one in which the limelight was taken from Brewster by Jones. To understand Jones' behavior in this meeting, a few facts from his history are needed. He was a 20-year-old enlisted man with only a few months of service who had been admitted to the sick list at another Naval hospital where a diagnosis of schizophrenic re-

action, paranoid type, was established. He manifested peculiar mannerisms and attitudes, seclusiveness, delusions, and paranoid ideas. Because of a fear that his food was being poisoned, he had lost 20 pounds prior to his admission and another 10 pounds while in the previous hospital. The note from this hospital, where he had remained for 27 days, reported that he had been treated with an ataractic drug with no noticeable effect. "His communications were incomplete, fragmented sentences, he was bewildered, his affect was inappropriate, he refused to take vitamin pills, maintaining they were poisoned." One day, the note tells, he had loudly denounced the corpsmen as fiends who were burning him with an electric needle and making a dope addict out of him. He raised his pajamas to show a scar on his thigh, which he claimed they had caused. The patient refused to quiet down despite repeated warnings, and was forcibly placed in the quiet room by several corpsmen, one of whom he struck.

When admitted to our ward he sat in my office with a fixed stare, holding his body rigid, and looked furtively about the room in a suspicious manner. His cigarettes, he told me, had been poisoned with acid at the last hospital, the medicine had been poisoned, he was getting electric treatment from the corpsmen and cosmic rays from the Communists. I learned that, at the age of 9, he had sustained a severe burn on the left thigh, which required skin grafts. His mother was pregnant at the time of the burn, he said; but as no sibling of this age was listed on his enlistment sheet, the pregnancy could have been fantasy, or the information denied or concealed. Shortly after this his father had died, and a month later his mother had remarried. The patient denounced his stepfather and said, "There aren't enough words to describe how bad he is." Shortly after the mother's remarriage, the boy went to live with the other siblings and seemed to have gone from one to the other because "they couldn't afford and didn't trust me." The group meeting now described was the third meeting which he had attended.

It began with Brewster complaining about the old beaten-up basketballs that were the only ones available in the courtyard. But Jones interrupted this complaint, to the mild surprise of Brewster, by saying, "Could I speak? I am having burns from

someone in the room." He stood up and lifted his pajama top to show his abdomen, meanwhile talking about Communists and his fear of "getting people in trouble if I talk too much." An older chief, suffering from a neurotic depression, examined Jones' abdomen and said, "I don't see any burns."

Then Jones went on to another delusion, "The men in the service are stealing money." The chief, speaking as a sort of elder statesman for the Navy, denied this, "I have had 13 years in the service, and I don't think you're right." Then he turned to Jones and advised him, "If you need to go to a surgeon, you go to a surgeon. If you need a doctor, you go to a medical man. If you have some problem of a mental sort, you go to a psychiatrist." Jones continued, perhaps giving evidence of his mental problem, "The cigarettes are full of acid and poison. Paint fumes are poisoning me."

Another schizophrenic patient, who had not previously spoken, said, "When I was 9 my mother's stomach began to get bigger, and finally she went to the hospital and had a baby, and when I asked her where she got it she said she had bought it."

I asked Jones, "Could it be that part of your difficulty is an emotional illness, and the things you are experiencing are not real?" He answered, with considerable feeling, "No." To him, this was real.

Now Brewster volunteered, "If you want me to prepare a legal brief for you to act as your counsel, I'll be glad to do it." Jones' suspiciousness was expressed in a very positive rejection, "No, I don't want you to."

Now Jones told us, "I wouldn't drink my coffee this morning. I pulled the cup away because the Lieutenant was dropping ashes in it." Brewster exclaimed, "Why didn't you tell me? Can't you trust me?" There was no answer.

It was my feeling that Jones had enumerated a number of fixed delusions and that unless we could direct the group in some other fashion, we would probably end up with an "endless" recitation of delusions. Taking the cue from the words, "Can't you trust me?" I now played a short record called "The Problem of Trust." This record presents a short dialogue between a mother and an adolescent girl who had been sitting in a car in

front of the house for some time in the evening, and the mother's words reveal her obvious suspicion and mistrust as to what the girl had been doing in the car. The record ends without any solution, without an idea as to what happened other than the mother saying, "Well, let me tell you something---." The patients listened attentively; there was no laughter, and there was obvious serious consideration. The record not only dealt with trust but with fear of pregnancy and anxiety about sexual behavior. Jones' mother's stomach had gotten bigger and he had not known why. When the record was through, he had regressed in a different manner; now his words were an unintelligible mumbo-jumbo.

I said, "Perhaps you don't want to talk about the record because of these Communist fears." He agreed, "Yes."

But a moment later he stood up, walked across the room to the middle of the group, took a cigarette from his pocket and lighted it from another man's cigarette. He borrowed an ash tray from the chief who had told him to see the psychiatrist, and then resumed his chair, sitting near me. He had taken a cigarette and lit it, though earlier in the hour he had said that the cigarettes were poisoned with acid and that ashes from the cigarette were poison. The pantomime which had been enacted was not discussed with the group because it was so obvious.²⁹ Now suddenly many of the patients started to talk, speaking of trust. Brewster told another sea story of a near-collision aboard ship. He himself commented, "This story may have something to do with what is going on in the group." This time, in his story, he had acted contrary to the captain's known wishes. Jones commented tartly, "I was taught to obey orders."

The communications which had occurred in this meeting could hardly be understood in rational terms. The behavior of Jones, however—both his lighting of the cigarette and his comment,

29. The interesting development here was Jones' turning from his disturbed fantasy to possible counterphobic behavior—smoking the cigarette—and to socialization, i. e., getting the cigarette light from another man in the middle of the group and borrowing the chief's ash tray. His behavior in the group was quite in contrast to his behavior in the previous hospital, where he had struck the corpsman and had required seclusion in the quiet room. After this meeting Jones began to eat better and the ward seemed to be in a therapeutic state.

"I was taught to obey orders"—was understandable and rational. There was no question but that the group felt extreme sympathy and empathy for this patient and wished to help him. They were obviously surprised when he lit the cigarette. It is difficult to say exactly what effect and meaning the record had.

On Thursday there were 18 patients in the meeting, and over half of them spoke at some time during the hour. Brewster was absent today. At the preceding meeting Jones had demonstrated his delusions, but had ended up with some evidence of his ability to cope with reality—"I follow orders." It was still somewhat obscure, however, whether the orders which he would follow would be those dictated only by his own unconscious or those by which others live. The group interest today was centered on this question; and the patients were obviously expectant of improvement in Jones and eager to help him.

The meeting opened with a question from one of the new patients, "What's going to happen when we leave here—and try to get a job? Will it mean failure?" But this question, though one that was usually of deep concern to the group, did not elicit much response. The patients were primarily concerned at the moment with Jones, and seemed to want to get on with his "therapy," as well as to satisfy their curiosity.

After a minute or so of silence, Jones asked, "May I say something?" He then began a confused monologue on the United Nations, Communism, politics, needles burning him, and dictatorship. His delusional system, however, now included a striking new idea—the idea that our meeting was a United Nations meeting. This is just as sick an idea, from the standpoint of appropriateness, as his earlier delusion that we were a bunch of Communists. On the other hand, it is a more socially adapted delusion, for the United Nations is a forum, a sort of community in which people with different ideas and feelings try to reach understandings, try to cooperate and can speak out forthrightly. Also, although he still feels that he is being needled and burned, he no longer thinks that the corpsmen are the culprits, he tells us. And though he still says there is poison in the cigarettes, he is smoking as he says so; it is as if he is giving us a signal that he

does not believe what he is saying, or does not want to believe it.

The reply to Jones came, as it had yesterday, from the chief. Referring to a recent Summit meeting of the Big Four, he expressed the view that it is possible to get along peacefully with other people, even when there are extreme differences between them and us. Jones caught up the chief's point and spoke at some length on his hatred of war and his desire for a world of peace, cooperation, and tolerance for others, regardless of race, creed, or color.

Another patient then said that his parents were of foreign birth but that this fact didn't affect others' feelings toward him. (This denial seemed to express a sense of belonging to this group.) Now there were comments in quick succession from a number of patients. A schizophrenic patient said, "There are always the little people,"—a statement which, like so many schizophrenic communications, had an almost poetic ring as he said it. He told in this connection about how his father—one of the "little people"—had fought the Mafia in Italy before he had come to the United States. And another patient, who had so far been sitting silent, listening and observing, spoke of oppression in terms of the struggle between good and evil—"There are always good people and evil people," he summed up. To Jones as he listened, the struggle between good and evil might well have related to his struggle with the repressed ideas that were tormenting him in the form of delusions and hallucinations.³⁰

30. At this stage of the meeting one incident occurred which I have not reported in context because it meant a great deal more to me than to the group. During the early part of the meeting one of the new patients sat looking through a magazine, occasionally flipping the pages noisily. This type of situation always poses a problem for the leader of a therapeutic community. When a new patient openly rejects the group, he should be directly confronted with his unsocial behavior at an early stage; otherwise he will probably constitute a more serious social problem in the group later. But the moment of confrontation must be carefully selected; it must be a moment when the group is moving in a cooperative spirit, both with each other and with the leader, so that the rebellious patient cannot hope to win its support of his behavior. The manner of confronting him, also, must be one which does not further separate him from the group by making him feel that he is being attacked.

In the present situation, I felt that the moment had come when the group was interestingly discussing the question of cooperation and tolerance for others. At this stage I said, "Just a moment, I want to interrupt the group" (implying that my intrusion was parenthetical to the discussion). Turning to the new patient, I said, "I wonder why you read the magazine during the meeting?" I did not tell him to

Then, after a short silence in the group, a schizophrenic patient began to press Jones gently for the evidence on which he had built his ideas of persecution: "What do you mean by this?" "Who was against you? (past)." "Why do you feel this?" (present) This therapeutic probing forced Jones to admit that he did not know. He was unable to put his finger on the persecutor. His next comment revealed his ambivalence in regard to the one father surrogate with whom the "here and now" was concerned: "Some doctors are for you and some doctors are against you." He added, "I don't know quite what's going on in the meeting." He had frankly verbalized his confusion.

The patient who had spoken of good and evil clarified the confusion as he saw it by saying, "Someone must rule. It's the doctor here." In other words, perhaps it is the doctor who will create order out of confusion. Jones agreed. Then he spoke of FDR and of how sad he had felt when FDR died, and of tolerance and cooperation and helping "little people." He moved on immediately from here to speaking of his own father who, he said, was a Democrat but was also cruel to him and deserted him and drank. "But I don't suppose everybody is a Democrat or feels the same way I do." He was speaking, I inferred, of his own fantasy of his own father as the bad father who had nevertheless belonged to the same political party as the good father. It was at this time that he began to sort out his confused "political" feelings from his personal feelings in a socially acceptable sense. In recognizing that not all people feel as he feels about politics, he is saying that, although we are different and have conflicting feelings on things, we can get along. Possibly also then these terribly diverse feelings deep within

put it down; I merely invited him to tell us why. But in the nature of his emotional difficulty, I knew that he would have some reason to protect himself from telling his secrets to the group. His reply was, "I don't feel I belong here. I wouldn't talk about my feelings in the group, but I will tell you in person." Now the patient has explained his behavior in terms of his feelings about the meetings (feelings which some of the other patients share) and has also spoken in terms of confidence about the doctor. I said, "All right. I will see you in the office this morning after the meeting," and then turned back and picked up the thread of the discussion with the group. The new patient at this point dramatically flung the magazine onto the bed behind him and sat quietly through the rest of the meeting, watching Jones attentively.

himself about the two fathers can be reconciled.

Then he spoke in some detail of his hospitalization and of his confusion, and he concluded his comments by saying, "I want to apologize if anyone is offended by what I have said, I apologize."

The socialization of this patient is indicated by his apology for offenses. But since he has not offended anyone, he is probably in effect apologizing for his father or for what he has said about fathers or for what he has thought about his father, for his feelings of guilt.

No reference was made to this aspect of his communication. Instead, I said, "You have separated politics from your deep personal feelings to some extent." Perhaps the tone of my voice, the manner in which I spoke, communicated to him the feeling that he had made sense and that I approved the rational comments which he had made to us. (Yesterday, it will be recalled, direct confrontation with his irrational statements had met with complete denial.)

He replied, "Yes . . . well . . . I get what you are saying, that it has something to do with cooperation in this place." So he has come around to saying, in effect, that he does know what is going on in the group meeting.

Over this period of a few meetings Jones' delusional defenses had to a degree been dropped, and he had begun to deal with group living. His communications to the group—originally incoherent and tangential associative productions based on his obsessional delusions—had become fairly meaningful and coherent. Moreover, the hold upon him of his fantasies with reference to personal persecution had been somewhat reduced by his acceptance of a ruler outside himself, perhaps even a slight change in his superego, fostering repression of the most destructive ideas with which he was obsessed.

At the close of the meeting other patients commented to me on the improvement that Jones was showing. They were clearly moved by this and were eager to help him. On the ward now, they told me, he would occasionally play ping pong with them, though he still tended to stay by himself.

If one were to see the Friday meeting in a silent movie,

without hearing a word that was said, one would know that it was tense, for there was an extraordinary amount of movement: the staff came and went throughout the hour; several of the corpsmen left the room to get chow, handling their keys as they went; the nurse walked in and out; many patients went to the water fountain to drink, and several moved from the group to their racks and back; a great many of them smoked and fidgeted and grimaced and moved their chairs about; and some of them were visibly shaken.

This was a reflection of the extreme anxiety which since yesterday's meeting had developed around Ingelson, a new patient with a homosexual conflict who had yesterday separated himself from the group.³¹

The meeting began with a corpsman setting up chairs for the patients, a thing that had never been done before (preparing the arena). The group sat fairly close to me, with Brewster in the speaker-of-the-house's chair and Ingelson directly behind him.

31. In the interview with him after the meeting it was evident that he was struggling desperately with his feelings about homosexuality but that there had been no overt homosexual behavior. He made such statements as "Most people are homosexuals." He was bitter and hostile and vigorous on this subject. "I admire the Marines for their rough attitude in regard to homosexuality." He was totally unaware of the genesis of these feelings, and that what he really was trying to do was to beat down these impulses in himself and his own fear that he was homosexual. It is interesting that he characterized his childhood as a "rough story"; he had been brought up "rough like the Marines," he said. The father whom he feared had never actually beaten him but, "I was forced to know my place in a rough fashion." He had several years of active military service. The patient was the fourth one of an enormous family, and the extreme importance of this is to be understood in light of his difficulties in the service and in the patient group on the ward. He joined the Marines to get something "rough" and had a great many fights, which he enjoyed. He had had no disciplinary difficulties. He was obsessed with the idea that he could not tolerate "unfair treatment between people," and was known to have complained of injustice to his commanding officer. Ingelson's diagnosis was passive aggressive reaction. There was a thinly disguised fear of losing control and doing violence. When he was transferred to the psychiatric ward from another hospital, no explanation was given to him, and he was surprised and bitter at being locked up.

He was full of hatred, not only of his own ideas which he projected upon others, but of inanimate things. "I hate television—I want to smash it." He had been repeatedly approached by homosexuals. This only further increased his anxiety and hostility.

Brewster opened the discussion, without a moment of silence. Turning to a colored patient, whom he addressed as chief (although his rank was really First Class), he said, "Someone (sic) called me a son-of-a-bitch. I don't think anyone should be called such names and I resent it. I want to slap him, and I told the corpsmen if they heard slapping it would be me. Chief, I wonder what you think about this?" By this device he had appointed a new leader to the group, or at least circumvented me. Why he chose the colored patient as his ally is not clear; and the "chief" obviously had ambivalent feelings about this, both enjoying his new status and being concerned to so temper his behavior as to be liked by the group. He did not back Brewster, but listened and accepted his appointed role with a benevolent silence, perhaps mimicking me.

Brewster was playing his caricature officer role to the hilt. One of the patients took him to task, "Why do you tell us to call you 'Sir' when we are playing ping pong with you?" He was speaking here about a field of operation where people meet, at least to some degree, on equal status—where winning or losing has nothing to do with rank; he was speaking also of the ongoing world of the ward, and of an experience in which all the patients could share.

Brewster reiterated, "I am an officer and a gentleman," moving the topic from the ping pong table to the green ward room table where he said the captain called him by his first name. "I always called him Captain," he said, "What would he do if I said, 'Bill' to him?" adding, "Of course, I've been on the beach drinking with him."

"Did you call him by his first name then?" I asked.

In reply, referring no doubt to enlisted men and officers, he quoted, "Never the twain shall meet." Then he said loftily to the group, "Of course if you knew enough about what Kipling was thinking, we could talk about it." Kipling, like the captain story, was calculated to be difficult for the patients to cope with.

I felt it necessary to come to the defense of the group against this depreciation of them, so I asked, "What was Kipling thinking?"

"I don't know him well enough," he replied, with a nervous

laugh. The others were silent but smiling.

Through the early part of the meeting Jones had been talking in a confused, disjointed fashion. He had regressed considerably as a result of the conflict on the ward, which he could neither understand nor easily tolerate. At this point he began to talk quite audibly, reciting the delusions which he had expressed in the earlier meetings. "That doesn't make sense," I countered. At this point he repeated his name and serial number, as if to identify himself. It seemed clear that little progress could be made with Jones in the present tense ward situation.

There was a pause and since Brewster had begun the discussion with an anonymous accusation, I now returned to this, "You talked about 'someone'. Since you were talking about someone on this ward I think you should say his name." He snapped, "I don't." But I persisted, "Well, I think you should." Then he said, "All right, it was Ingelson." (Pause, looking around.) "I don't see him."

Ingelson, sitting directly behind him, said, "I'm here."

Other patients again began pointing out to Brewster how an officer should behave; and suddenly Jones spoke up, "I respect you as an officer, but you're a patient like the rest of us."

Then Baxter, a schizophrenic patient, burst out angrily, "Yesterday the lieutenant told me that if I had any questions I wanted him to answer he would. Well, I was reading a book and came on the word 'neurosis' so I asked the lieutenant what it meant. He said, 'Look it up!' How do you think I felt?" and he burst into tears. There was an awkward silence, and Baxter stood up, walked to his rack at the far end of the ward, and covered his face with a blanket to hide his crying.

I said, "Will someone go over and see Baxter?"

The lieutenant walked over, talked to Baxter for a while, and then returned, but Baxter did not come with him. I then went over to the patient, who was very tense. He was crying, he told me, because his grandmother had died while he was in the previous hospital and they wouldn't let him go to her funeral. Then he repeated, "How do you think I feel?" (i.e., now). I suggested that he return to the group, which he readily did after drying his eyes. As we returned Ingelson, who had been the

provocateur, explained that he was angry and had refused to talk because "the lieutenant calls me Private and there are no privates in the Navy."

Brewster arrogantly demanded, "Well, what is your rank?" "I am SA."

"Well, I'll call you Seaman."

Another patient commented, "There's a lot of tension on the ward and restlessness."

"I don't belong here. I'm an officer," Brewster said.

Jones, who had previously been carrying on a monologue about his delusions, suddenly spoke out again: "Well, if you hit one of us you'll be a seaman again."

Not replying to this, Brewster turned to the "chief": "Do you think I did right in not hitting him?" (Ingelson).

The "chief" replied, "Yes, you did right to control yourself."

Just before the hour ended, a new patient said to me, "I don't understand what Jones is saying (about world conflict, Communism, and peace)." I interpreted it and Jones smiled and said, "Why won't you let me talk?"

The meeting was summarized in terms of conflict now and in relationship to early life conflicts and the problem of controlling one's impulses.

I shall now turn to the sixth and last meeting in this sequence, the meeting on the following Monday. Since the last meeting there had been 12 admissions, and there were now 27 patients on the ward. The tension of Friday had relaxed, and the Monday meeting was a quiet and thoughtful one, concerned primarily with the integration of the many new patients in the group.

The delusional Jones began the discussion by asking, "Why do people spit on food in the galley?" Then he complained that there was too much seasoning on the food and, with many references to race and religion, that the radio was being used as a psychological device to reach him. He spoke haltingly, with long periods of silence, but he continued speaking for some time. He even interpreted his own feelings by saying that he only felt comfortable when he was talking.

Brewster was more subdued today and more a part of the

group, perhaps because he knew that he was being transferred to the officers' ward after the meeting. He made only one reference during the hour to "officer and gentleman," and this was made almost as if he were playing a record without much feeling. At one point he actually sided with Jones and supported him, at which moment Jones stood up, walked across the room, borrowed a cigarette, then turned to Brewster and repeated his previous pronouncement: "You're not an officer here; you're only a patient like the rest of us." Brewster now told about seeing the chaplain in Hawaii and said, "Everything changed at that time. Maybe I was having hallucinations; and I said to myself, if this is it, God take me." This was a considerable admission for him to make, particularly the use of the word hallucinations.

Jones spoke of his "dreams about Christ." Immediately following this, a new patient who had not been in any of the previous meetings said: "Why is it that people laugh at you if you go to church?"

Jones, it seemed, was considerably changed, laughing and joking in this meeting, although not quite appropriately; his affect was appreciably changed from the marked suspicion that characterized him in his early meetings. He had been working hard on the ward, swabbing the deck, and he complained in the meeting that we were overworking the patients.

A patient, ignoring the complaint, suggested that perhaps Jones' fear and distrust of people related to his childhood. A chief who had been admitted over the weekend said, "It could be." Jones "was wrong in suspecting the service"; he himself had been in combat and, "You can trust your fellows in the service." Then, gently and intuitively, he asked, "Couldn't it be that childhood has something to do with it?" Jones acknowledged, "It is possible."

At one point during the hour, when Jones was rambling in an incoherent fashion, a new patient said, just barely audibly, "He's nuts." This was a stage in the acculturation of the new patient that could not be ignored. I turned to him at once and said, "What did you say?" He looked down at the deck and did not reply. I continued, "Of course you said something," adding slowly, "Everything that is said is important and we want to

know." He remained silent, so I turned to Jones and interpreted the remark in words which were acceptable: "He thinks you are confused; do you think you are confused at times?" He said, "Yes." The accusing patient, it was clear, felt uneasy and guilty. Since no one had given him approval or agreed with him or laughed at the "joke," he undoubtedly sensed that this sort of talk was group-disapproved.

I summarized the meeting in terms of difficulties about being different, citing the patient's example of being laughed at for going to church, and in terms of the probable relationship between present attitudes and childhood experiences. Throughout this meeting Ingelson had been silent. But on the ward he was no longer a disrupting and threatening factor.

THE THEME OF SUICIDE IN THE COMMUNITY MEETING

At times, particularly when there was a preponderance of deeply depressed patients in the group on the ward, the theme of suicide was brought up in the community meetings. The following two meetings illustrate how four depressed patients tried to cope with the current feelings, their childhood memories, and both suicidal and homicidal fantasies. They also illustrate how patients with a common meeting ground in the genesis of their illnesses can, with some guidance from the therapist, help each other as they help themselves, seeing themselves in the mirror of the other's story.

The major themes of these meetings—death, suicide, and murder—developed primarily out of the communications made to the group by four patients—Atkinson, Waters, Frederick, and Gomez—whose histories show a number of features in common. All of these patients were to some degree homeless. All were trying to run away from their unhappy childhood conflicts and had attempted to find refuge from them in the service. All had got into difficulty in the service. All were intent on self-destruction and had unconscious death wishes toward a parent, as was manifest in their stories. Death was the theme which brought them all together for the attempted resolution of conflict.

Since the first of these patients, Atkinson, was the dominant

figure in these meetings, his history will be briefly reviewed here. He was a young Marine who had been transferred from the Far East to Oakland following an episode in which he took a military vehicle on unauthorized leave and drove it deliberately into a taxi in an attempt to kill himself. (He had an amnesia for this episode.) When faced with the court martial, he feared that he would become insane; he could not stand confinement. The medical officer concurred, and he was admitted to the psychiatric service after extensive neurologic study.

While in the hospital awaiting the court martial, he attempted to induce a guard to kill him with a pistol; the diagnosis schizophrenic reaction, catatonic state, was established. His fears about becoming insane in the brig had materialized outside the brig.

But almost a year before this, when his father had died, the patient had responded with various symptoms (phobias, ideas of reference, and suicidal ideas), and a month before the "accident" he had begun to hear his father's voice. Shortly after the father's death, the patient's wife had filed divorce papers in the States, and the Red Cross had notified him in Japan that she had had a nervous breakdown. According to his account, an officer to whom he appealed at this time for emergency leave of absence refused, saying, according to the patient, "When (sic) your wife dies, I'll send you home." After this he developed insomnia and anorexia and began to cry.

His father had been an alcoholic, cruel, disagreeable, and critical of everything that the patient did. One night when the father was beating the mother, the patient took a rifle and shot at him. After this the father was even more cruel than before, and finally forced the boy to leave home. This, then, is the constellation of the murderous impulse which drove Atkinson to join the Marines.

Then, in the service, the impending disruption of his marriage confronted him with the prospect of losing his infant child, with whom he strongly identified, to a mother who, he felt, was unfit. He was now unable to stand by his own child, just as his father had been unable for other reasons to stand by him. With the refusal to grant him leave, and the manner of it, he turned toward himself the aggressive feelings which he had earlier felt toward his father. The two episodes followed in which he tried to get other

people to kill him—first, in a somewhat anonymous fashion by driving his jeep into a taxi and, second, by asking a guard to shoot him. But by this time he was quite psychotic.

The first of the two meetings reported here opened with a patient talking about his delusion that he had killed someone in an automobile accident, telling the group that he was confused and mixed up and trying to straighten out his thoughts. Following this, I played a Gordon Jenkins record—one of the dreams from his series, "Seven Dreams"—in which a girl sings a plaintive, low-down, lonely blues:

If I owned that lonesome whistle,
If that railroad train was mine,
I'd find a man a little further down the line.
Far from Crescent City's where I'd like to stay,
And I bet that lonesome whistle would blow my blues away.

In response to the record, Gomez,³² who had previously been afraid to talk for fear that if he recalled why he had tried to kill himself he would do it again, now told us about a train that used to go past his home every evening when he was a child. He wondered where it went. He imagined that it went to Mexico, but when he got older, he found it went only to the next town. One day he had walked to the woods, following the tracks to see how far they went. But they went beyond the woods, beyond the little world that he knew. He made up his mind that sometime he would go on that train, but he never did, for by the time he had grown old enough to do so, the train had been discontinued. Here I summarized the theme, "You Can't Go Home Again," and we discussed it.

32. Gomez, a 17-year-old patient of Mexican extraction, had been admitted to the hospital after he had broken the windows in the brig and cut both wrists in a clear suicidal attempt. In his interview with me he said that he had frequently wanted "to run away from it all" and felt that he was destined to die before he was 21. At the age of 14, he began to drink heavily. He had never been able to get along with his mother, and his father, he said, "began to dislike me and beat me with a rubber hose." These beatings, which continued to be administered even after he was 17, must have made him feel murderous toward his father, but his major conscious hostility was toward his mother. He joined the Navy when he was "literally driven out of home."

Then Atkinson told the group about the accident in Japan in which he had crashed into a taxi, seriously injuring the driver, and about his amnesia for this episode and how he had been told about it. Another patient said, "Perhaps he doesn't want to remember."

"Perhaps," I suggested, "you are depressed over something that happened earlier."

"Yes, my father had just died, but I wasn't thinking of it at that time," he said; "I don't know what I was thinking." His father, he told us, had always wanted him to "follow in his footsteps." At this point, instead of the general summary with which I customarily closed the discussion, I made an interpretation concerned primarily with this patient—that it seemed as if he wanted to follow in his father's footsteps even into death, and that perhaps he would feel better when he could remember and share with the group the feeling of not wanting to remember for fear of what the memory would mean to him. I made no interpretation of the deeper meaning in relationship to the murderous constellation.

When the group assembled for the next day's meeting, the patients sat close together, mainly congregated opposite me and around me. As soon as we were seated, I said, "There are fewer patients here today." This remark was intended only as a friendly gesture, a conversational gambit to get things started; I did not want a silent hour. Then Waters³³ remarked conversationally, "It was very quiet on the ward last night, and I slept well." Gomez said, "I didn't. I kept waking up all night and falling asleep. Why does a person do this?" Atkinson replied, "I had the same difficulty last night. There are thoughts on our minds."

Waters, who was clearly a helper, identifying himself with the leader, had expressed a feeling of comfort; but this was contradicted by the two patients who had spoken in yesterday's meeting, who had, in effect, taken the lid off an important part of their lives. Anxiety had clearly been provoked and unrest in these two patients by yesterday's hour. The discussion about the death of father had evoked intense feeling.

33. Waters, a retired master sergeant, was a chronic alcoholic suffering from alcoholic hallucinations and delusions, with paranoid ideas. In his drinking he was running away and intent on a type of self-destruction.

Then Waters said, "I want to tell a dream I had." In the dream, he told us, he was trying to comb his hair, but it wouldn't lie down; it kept falling forward. So he took off his head, put it on the table before him, combed his hair smoothly into place, and then put his head back on.

It is difficult to say why Waters told the dream. Partly, perhaps, because he had remembered it when he had listened to Atkinson yesterday tell about his feelings following his father's death, and partly perhaps to keep the group discussion going. It was not a recent dream. It had occurred several years earlier. But the fact that its memory had persisted, and that he still sought an understanding of it, was much more important than why he chose to tell it at this particular time. I asked him if he was upset about anything at the time of the dream, and he said, "Yes, my mother had died just before that."

The bizarre content of the dream evoked no visible reaction in the group. Rather, the patients seemed to assume that the dream meant something, and began to question Waters about it. In reply he told how he had gone to see his mother after she had lost her leg because of diabetic gangrene. She knew that she was very ill, and she asked him to see that she had a Catholic burial. He had told his stepfather (who was a Protestant) that he would do this, but when his mother died, the stepfather did not even notify him of her death until after she had been buried. (The rage that he felt about this was profound, and his feelings toward the stepfather evoked again the early Oedipus conflict.) It was at this time, he said, that the dream occurred. Waters said, "I am going back after my stepfather dies and see that my mother gets the sort of burial I promised her."

Now it is not quite clear what the interpretation of this dream is. Many ideas come to mind, of course, aside from the symbolic meaning of hair, castration, et cetera. The first is that something had risen to haunt him which must be corrected and made straight. But there was the further relatedness of this dream to yesterday's communication from Atkinson in the identification of himself with his mother—that is, the mother had lost her leg and in the dream he had "lost his head," But he had put it back; he had undone the amputation (or castration). In addition, he had undone

something else. He had even to some degree, perhaps, symbolically undone the mother's death in as bizarre a way as Atkinson had gone about his attempt to have a reunion with his father. In this regard perhaps the loss of his head is an identification with his mother in death. Perhaps too the straightening out of matters by putting his head back is the straightening out of the burial matter, the fulfillment of his promise to his mother. The important thing that he is saying is that mother had died, and there had been strange feelings evoked in his grief.

At this point Frederick³⁴ entered the discussion in a characteristic manner. With a sort of feigned naivete, he asked, "How are Catholics buried?" Somehow or another, by emphasizing the idea of Catholic rather than the idea of burial, he had attempted to divert the group, not only to himself, but away from the topic under discussion. A patient sensed this, and said, "That isn't the point; the point is that he had promised to do something." After this return of the group to the subject at hand despite his resistance, Frederick became increasingly anxious. This time he attempted to blot out Waters' dream by telling even more fantastic dreams—dreams in which, he said, he had been to heaven and hell. He seemed to speak for God in these dreams, and to know that there is a hereafter.

Another patient asked, "Did you dream this?" which turned out to be a very penetrating question. Frederick replied, "I am not sure whether it was a dream or not."

This was further clarification of the information being transmitted; but, even more important, once Frederick's communication was acknowledged as a fantasy, dream or nondream, and not

34. Frederick was a 20-year-old patient who had been sent to this ward for the second admission because, while working with airplanes in the service, he had done several things which endangered the lives of others. In his interview, he told me that his parents were divorced when he was 10, and his mother had then married a man very much younger than herself. His mother, he said, "ran away and took my brother and me with him." The "him" is a slip of the tongue and relates to the next statement that the patient made—that he then went to live with his father. The father, who had remarried, was an alcoholic. The patient said that he "ran away" from his father and went into the service. This patient's extreme, clown-like behavior and his fascination with exotic and dangerous things may perhaps have been a denial of how he felt toward his alcoholic father, but his major conscious hostility was toward his mother.

as a diversion, its essence became meaningful—namely, he was talking about death, heaven and hell, and God, and his wish that there will be a hereafter and perhaps a reunion with the mother and father. This stimulated Gomez to ask, "Does the world stop when you die?"

"No," Frederick replied. Then he quoted the Bible as an authority for his position, concluding categorically, "We don't argue about the Bible. It's silly to question the Bible."

This was another sort of smoke screen for, by his use of the word "silly," he invited disagreement. But again the intended diversion turned out to be a very directing phenomenon. Atkinson asked, "Why is it silly to question the Bible? Isn't it open to interpretation?" He was now questioning the right of another member to question his right to question. And from here he moved on immediately to the subject which had the deepest meaning for all the vocal members of the group—the subject of suicide.

He had a right, he asserted, to kill himself if he didn't hurt someone else. There was considerable discussion about this, which I interrupted to ask, "Is it possible not to hurt someone else if you destroy yourself?"

A number of patients took the position that it was not and that Atkinson's thesis involving the "if" was meaningless, for no one is alone. Atkinson defended his thesis, assuming the "if" to be true. It was perfectly obvious that he could not be reasoned out of his position for reason had little to do with his feelings on the subject. To clarify the point, I pointed out to them that there was an inconsistency here; and to substantiate it rather than talk about the "if," I said to Atkinson, "Yesterday you told us about a suicidal attempt which you actually did make, and in which you actually did hurt someone else. When you drove the jeep into a taxi, the taxi-driver was seriously hurt, but you were not." Since he had not told the group about his attempt to get the guard to shoot him, and thus assume responsibility for his death, I said nothing about this episode. But I did add, "It is interesting too that, if you met death in a situation of this kind, the other person would have to struggle with the problem of having killed you. What you propose would actually disguise the suicide or deny it, for, though you say that it's OK to kill yourself, yet you are having someone else do

the job, to make it appear as if it is not suicide at all. Don't you think there is some inconsistency here?"

There was a moment of silence and the idea that suicide is similar to murder seemed to sink in, but nobody seemed to want to say anything about it. Frederick once more attempted to divert the group, this time by returning to the word "Catholic" with a reference to the Pope's recent vision . . . "A preacher in a foreign country has been having some visions," he said. Despite the provocative hostile nature of his remark, his manner of speaking was semi-humorous, rather than malicious; and the group, undoubtedly perceiving this, let his comment go unchallenged. However, it had an effect, for soon afterward Gomez began to speak, saying that although he was a Catholic, this would not keep him from suicide. I asked him why, and he replied, "If I were in love with a person, even if the church disapproved it, it wouldn't keep me from marrying."

He was saying that love to him was the strongest power in the world, and it was at this moment that a meaningful link between death, murder, and suicide was brought to play.

In terminating the meeting, I briefly reviewed and interpreted the main topics which the group had talked about—the question of death and of what happens after death; the desire for a sort of reunion with mother and father; the dream in which there was an identification with the mother and an attempt to right something, perhaps the burial; the question of the "right" to kill one's self—where does such a right come from? Who gives it? And, since suicide always hurts someone else, can there be such a "right"?

I then brought the interpretation around to the origin of feelings about death in terms of the foolish need which adults often feel to deny death by some sort of subterfuge—for example, by telling the child whose father has died, "He has gone away." The parent's fear of facing death thereby confuses and deeply disturbs the child. I touched also upon what "going away" means to the child—the feeling of being deserted; upon the adolescent's confusion about death and his agonizing wonder about the hereafter; and upon the fact that it is only later in life, when one really comes up against death, that one begins to get even an inkling as to what it means. This was the note upon which the meeting ended.

CHAPTER X

COMMUNITY MEETINGS: SOME CHARACTERISTIC SITUATIONS AND TECHNIQUES

Certain types of situations recurred so frequently in the community meetings that we inevitably developed extensive observations on them and, I believe, some practical skill in dealing with them. In the following pages I shall present some of our experiences. Since, as in life itself, we learned both from our failures and our successes, I shall touch upon both here. But I am not, in any pedagogical sense of the word, attempting a formal and comprehensive guide on what to do and what not to do when these situations arise.

ATTITUDES TOWARD INSANITY

Delusions and Hallucinations. In terms of diagnostic categories, the largest single group of patients on the ward during the period of the experiment were psychotics (44.4 percent), and just over 90 percent of these were schizophrenics. Delusions and hallucinations, therefore, played an important role in the therapeutic community. Not only did these symptoms preoccupy the sickest patients; they also tended, by their "strangeness," to increase the nonpsychotic patient's fear of insanity—the very existence of which he wished to deny—and his sense of stigma at being in a mental hospital. Coping with this problem on a healthy social level was a major part of the work of the therapeutic community. Since the patients had no actual escape from the ward, some *modus vivendi* had to be established by which the delusional and nondelusional patients could live comfortably and therapeutically together.

It did not seem to be an insurmountable disadvantage, however, to have both psychotic and nonpsychotic patients on the same ward. In fact, in many instances each seemed to have a highly

therapeutic effect upon the other. By observing the psychotics, the less acutely ill patients were often jolted into pulling themselves together so that they would not become, as they saw it, sick like this; often, also, in the cooperative atmosphere of the therapeutic community, their fear was offset by an intense desire to help those who were obviously so much sicker than themselves. On the other hand, in an environment relatively free from the fear of violence, the psychotic patients often renounced their delusions and hallucinations, or at least altered them to forms that were socially acceptable. As a result, a striking improvement was sometimes effected even within the short period that they were on the ward.

To some degree hallucinations and delusions were thought of in our philosophy as roles or parts that men played in the drama on the ward. But they were not regarded as fixed roles, incapable of modification. Our approach was one that sought to remove or at least largely decrease the fear that surrounded these psychotic manifestations so that the members of the community could talk together and live together in confidence. The therapy employed combined the social point of view with the understanding that is available in psychiatric theory and practice.

In the community meetings there was an amazing tolerance of psychotic symptoms, and the tone of tolerance set here also carried over into the attitudes shown during the other 23 hours of the day on the ward. Many patients confided their hallucinations and delusions freely to the group.

On occasions, the impact of another patient's comment was exceedingly effective. In one meeting, for example, when a psychotic patient was expounding his belief that the patients on the ward were about to kill him, another patient commented, "Gee, if you really believe that, you must be nuts," which had a sobering effect on the psychotic. But the most interesting part of this exchange was that it was all said in a matter-of-fact conversational tone, as if they were two average people talking over a poker table.

In general, delusions were regarded as a part of the "normal" communication process, and the fact that they evoked little consternation enabled the patients to talk freely of them and, as a result, to take a more mature attitude toward them.

Use of the word "Crazy." The patients rarely used the word "insanity," but the word "crazy" cropped up quite frequently in the community meetings and, on a ward where psychotics and non-psychotics lived together, it was always a supercharged word. Sometimes it was used jokingly, the joking tone thinly disguising an underlying hostility and fear; and sometimes it was used as an open and unveiled communication of hostility or fear. The reactions to the word also varied. Some patients were obviously stunned and frightened by it. Others took a cavalier attitude—"Who's crazy? It may apply to you, but . . ."—which enabled them to deal with their fear of insanity by dividing the group into those who were "crazy" and those who were not. A serious attempt was also made by the group at times to examine the meaning of the word in relation to themselves.

The joking approach to the word "crazy" is seen in the following example. The patient in this case was an 18-year-old seaman named Mitchell, whose diagnosis was emotional instability reaction. Outwardly, he was a friendly, childish, clowning, innocent but mischievous young man, but beneath this surface there was thinly concealed depression and aggression. His practical jokes at the air station which was his post of duty had culminated in one that, by causing a great amount of high octane fuel to be spilled on the runway, had nearly resulted in a disaster. It was this "joke" that had landed him in the psychiatric hospital.

In the community meeting one day he interrupted the discussion with a joking reference to the "tall fences with the barbed wire on top" that enclosed the courtyard at the side of the ward. He went on to speak of the ward as a brig, all of this with such gestures and facial expressions as to produce a certain amount of laughter in the group, who were not averse to hearing the mental hospital spoken of in terms of a prison. Then he said that no one had told him that he was coming to a psychiatric service and that he had known it only when they "buzzed the door."

"I'm not crazy," he asserted (and indeed he was not). There were loud guffaws at this. But the laughter was somewhat sadistic; the other patients were laughing at him as well as with him, for his conduct on the ward had been conspicuously clownish. His sensitive realization of this now led him to explain that he was

really a comedian and that he liked jokes. He even related the incident that had sent him to the hospital—the spilling of the octane gas on the runway. At this, another patient exclaimed, "You belong here." This brought down the house.

But when the word "crazy" was used as an open communication of hostility or fear, it was never a laughing matter. For example, one psychotic patient—a man who had come into the hospital so bound hand and foot, waist, knees and chest, that it took us a long time to untie him—refused to go to the community meetings. But from his bed at the end of the ward he would call out from time to time, "This is the nut ward," or "You are all crazy nuts."

No one laughed. In this hostile use, the words "crazy" and "nut" aroused deep resentment, for they intensified the fear of insanity and the feeling of stigma at being in a mental hospital. Though this patient was very sick, the other patients wanted to deny it. One of them expressed what many of them were eager to believe, "He is only doing this to attract attention because he is on a crazy ward." This was a means which the patients often employed for denying the very existence of insanity.

The patient himself knew how sick he was; he greatly feared insanity, and his experience with seclusion rooms and restraints had been especially terrifying to him in this regard. Now he was expressing the contempt and rage which such treatment had aroused in him by depreciating and humiliating others as he had been depreciated and humiliated.

For several days he became the scapegoat of the ward, but the attitude of the other patients toward him changed somewhat when I described to them the condition in which he had arrived on the ward and his experiences in the seclusion room in the previous hospital. Alone with me in an interview which he requested after this, he was depressed, crying, serious, and even friendly, not at all the Peck's bad boy of the meetings.

I should now like to illustrate briefly the way in which the group attempted at times to examine the meaning of the word "crazy" in terms of their own situation. In the meeting from which my example is drawn, the social worker had explained the hospital's routine procedure of sending letters to the patient's

next of kin informing them that he was on a psychiatric ward. Following the explanation, there was a rather long silence. Then a mildly schizophrenic patient observed anxiously, "People outside get shook when they say 'psychiatric hospital'—it means crazy." Another schizophrenic said that when he went to the hospital in Japan he thought this meant that he was crazy. "But," he added, "the doctor soon straightened me out on that. There are all sorts of psychiatric patients."

The first patient repeated, "People think NP patients are out of their heads." There was another long silence. I finally said, "I wonder what that means—'out of your head'?" A patient replied, "It means a break; you don't know your name, you don't know who you are, and you can't make sense; a total break, you're gone, you're insane. But I'm not really qualified to say." (An insane person does not go out of his head, or out of his mind, but wholly 'in his mind' as Santayana said.)

Several other patients also gave tentative explanations, always stating, however, that they were not really qualified to answer this question. In effect, they wanted *me* to answer it. I did so, and at the end of my discussion the patient who had first tried to define the term asked, "Is it true that people who fear they are going insane never do; that everybody at some time feels this way?" Through the rest of the hour the group discussed the question of what insanity means, in an attempt to arrive at rational conclusions about themselves and their current condition. One comment which was widely accepted was that sometimes people "act crazy" to reassure themselves that they are in control of themselves and that the NP status sometimes gives them the license to do so. In support of this view, examples were cited of a patient who had "behaved like a nut" on the day when a certain captain had made inspection and a patient who had urinated under the quiet room door on one of the wards as the Admiral passed by on inspection.

The Locked Ward. Unlike many therapeutic community projects, the experiment at Oakland was conducted on a locked ward. This situation did not create any insurmountable problems, but it was occasionally referred to in the community meetings. At one meeting, when a patient was talking about his fears,

another patient said, "Maybe he feels uneasy about being locked up. When I first came on the ward, the first day, I felt like breaking out." I was interested that he ascribed this feeling to the first day, but I did not inquire whether he still felt the same way, as he probably did. Instead I said, "Ask him." The first patient did not reply, however, but another patient said, "I feel comfortable here. I feel I'm going to be helped. This is the first time I've been able to sleep in three nights." I said to the patient who had introduced the subject, "See, people feel differently about the closed ward, don't they?" He rather doubtfully replied, "Yes, I guess they do."

The lack of liberty on a locked ward was an inevitable source of frustration, and the patients were always deeply concerned about whether they were to go on from the admission ward to another locked ward or an open ward. But the large locked ward seemed to have a totally different effect from that of solitary confinement, particularly on patients with claustrophobia. One patient who was admitted to the hospital from the brig following a suicidal attempt confided in the community meeting, "I had a fear. I always hated being locked up. I got the shakes and haven't been able to stop since. My Dad used to lock me up in the chicken house when I was a child, and I'd have to sleep there. He used to do this to scare me. I can't stand being locked up." Though this patient was markedly depressed and fearful of military confinement, he did not complain of being locked up on the ward.

Violence. For the most part, though there was intermittent talk about violence, very few episodes occurred. It may sound overly simple, but the fact of the matter is that violence was not tolerated on the ward. The mores of the therapeutic community tacitly forbade it. This was sometimes dramatically illustrated in the meetings. On several occasions when a patient clenched his fist and drew back his arm as if to swing at someone, another patient would merely place his hand on his forearm. This was almost always enough; the clenched fist relaxed and the threatening arm dropped harmlessly. In only one instance did a patient strike another in a community meeting; and he apologized for his action at the end of the meeting and sought

an immediate interview with me in an intense state of panic and guilt to explain his own anxiety and seek support.

The lack of visible anxiety in the staff's attitude set a tone of relaxation and tolerance in the community meetings. The great care with which they chose their words to avoid the implication of attack or accusation against patients led the patients to conduct themselves with equal courtesy. On the few occasions when staff members spoke less skillfully, there was an almost immediate repercussion.

In addition to the community meetings, the patients always had recourse to an individual interview if tensions mounted. Many a patient—and many a corpsman—came to my office to tell me that he felt like hitting someone else, and he seemed to go away relieved that he had been able to take this feeling out in talk instead of action. By this means, and others, there was a constant feedback of information which gave me forewarning of many brewing difficulties and threatening situations between patients on the ward.

Moreover, in the few instances when very sick patients had great difficulty in controlling themselves or lost control, the temporary nature of this behavior was impressed upon the other members of the community by the fact that such a patient's recovery took place visibly on the ward, and not hidden from sight behind the closed doors of the seclusion room.

The significance underlying violence was often revealed in the meetings. One meeting, for example, was dominated by a patient who had been placed in the seclusion room the night before by the Officer of the Day. As the meeting opened he was extremely agitated and he talked under such pressure that a number of the other patients shouted "Shut up!" He quieted down for a moment, and then he came toward me, waving his hands in a threatening gesture. Without moving from my position, I asked him, "Did you think I was afraid?" He replied, "No." Then he turned from me and started toward one of the patients with threatening gestures. Other patients told him to shut up and sit down, but he continued to gesture wildly, talking incessantly. Finally I said to him, "You're afraid. That is why you talk so much." He was, I felt, afraid of insanity, for this

was what he had been talking chiefly about. By placing him in the seclusion room, the doctor had corroborated this fear, which was now beyond his power of control.

He answered, "No one in this room is insane, and you know it, Doctor. When I was in the VA hospital once, I was insane once, maybe." I repeated softly, "You're afraid . . . of what?" And it was when I talked about fear that we got the first glimpse of a genuine emotional reaction which was appropriate. He hung his head, and I thought for a moment that he was going to cry.

BEHAVIOR

The patients in the therapeutic community knew that the staff would not mistreat them or put them in the quiet room, and the community meetings gave them daily redress against any possible violation of the regulations in this regard. But they knew also that acceptable social behavior on their part was consistently and firmly expected. The fact that the corpsmen were deprived of the punitive use of the seclusion room forced them to face the patients on a more equal basis and to develop new ways of dealing with threatening situations. They found the new ways more effective than the old, and more pleasant to work with.

Courtesy. Mutual responsibility for courtesy in all staff-patient and patient-patient and staff-staff relations was repeatedly stressed. On the staff's part, their conduct toward patients was constantly analyzed in the staff meetings; in corpsmen meetings, also, this matter was emphasized, and any courtesy which came to my attention, either by observation or report, was discussed personally with the corpsman involved. The cardinal rule for the staff was never to humiliate a patient, either by himself or before others. The therapeutic community operated on the basic assumption that the dignity of the human being should be respected in any state of mind, but perhaps particularly in insanity.

On the patients' part, two rules of conduct seemed to be taken for granted and needed no emphasis: that they would not swear in the presence of the nurses and that they would show respect to the staff officers on the ward. In the community meetings

attention was paid to certain seemingly minor aspects of proper behavior, such as using ash trays, sitting in chairs, and not obsessively interrupting when other patients were speaking. But the good behavior expected in this regard was the good behavior that one has a right to expect from a group of young people in military service, rather than the etiquette expected at an officers' club or a tea party.

In general, every possible courtesy was shown by the staff to the patients, and the patients reciprocated to a remarkable degree. But we did not set unrealistic standards of behavior, and we carefully differentiated between behavior that was no concern of the therapeutic community and behavior that infringed the essential rules of ward decorum. For example, if a patient wanted to complain about the food, that was his privilege. But if he wanted to throw food around, his behavior was no longer a matter that concerned him alone; it also concerned the ward.

Recognizing the power of imitation, the staff members and I tried in all contacts with patients to set an example in simple courtesy. I saw each patient who was admitted during the working day within an hour of his arrival, and my first contact with him was, as I have said, a firm handshake. In my individual interviews and in the community meetings I made it a point to show by posture and attitude that I was interested when the patient was speaking; and as evidence that I had listened carefully, I also referred in my summaries to any significant contributions to the discussion, attributing them by name to the patients who had made them. Whenever possible I addressed the patients by their last name, as in the military custom, or, in the case of officers and petty officers, by their rank or rate.

Profanity. Profanity was no problem in the meetings for it was simply taboo, and the taboo was established by the patients themselves. A patient who swore "in the presence of women" was quickly denounced by the others. Sometimes, too, before anything had been said about it, the patient himself would apologize to the nurses if he had used a swear word in a moment of anger.

Baiting. Continued baiting, teasing, or provoking was interrupted and, whenever possible, analyzed in the meetings, and

sadistic baiting was always peremptorily stopped; when it was directed against very sick patients it could markedly exacerbate their illness. On the other hand, it was possible for the sickest schizophrenic on the ward to bait the group to the point where they would accuse him of "acting crazy" and demand that he be punished for it and in this way become the ward scapegoat. One of the most sadistic baiters on the ward was a chronic schizophrenic who had been in and out of mental hospitals for years. In one meeting, while a patient was talking about his delusion that the staff were shooting him with electricity, he yelled out, "What do they do? Buzz you, kid?" (i.e., give him EST). In another group a psychotic patient persistently baited the corpsmen, trying in vain to provoke them into maltreating him by calling them in a hissing manner "queers" and "pimps" and "dirty rotten bastards."

Setting Limits on Behavior. Limits on behavior were set by direct command in instances of flagrant defiance of ward regulations. Unless the leader thus makes it clear that certain types of behavior are not tolerated on the ward, widespread defiance might become a serious social problem.

Such commands should be issued, of course, only in regard to behavior that clearly differs from behavior which the other patients feel that they could properly indulge in. By taking a firm stand on clearly defiant individual instances, the leader usually wins the confidence, support, and respect of the group, and they will ally themselves with him in the issue. Thus the patient who flagrantly violates the rules finds himself alone, a situation that is more uncomfortable than conforming.

In issuing a command, however, the leader should never make or imply a threat. An "either-or" or an "or else" will cause the more aggressive patients to test him out. Punishment for bad behavior is a familiar situation for them, and one with which they know how to cope. But when they are met only with the insistent expectation of good behavior, and when they see other people responding to this expectation, the social pressure to conform will have more force than a threat.

I did not hesitate on occasion to use my status authoritatively as a form of social pressure in dealing with patients on

important matters of ward decorum. For example, in one meeting an accusation was made that a "psychopath" in the group, named Watson, had been mistreating a very sick schizophrenic patient, Lewis. Spoken directly to Watson, the accusation was, "You manhandled him. One night he was near your bunk and you pushed him away and you said you'd hit him in the nose." At this point I interrupted (carefully choosing words to state a situation that existed and must exist rather than in this case issuing an order), "No one threatens anyone on the ward here—doctors, nurses, corpsmen, patients. Lewis is very sick, though he is better today. He knows when you are talking about him and what you are saying, and when he gets well he will still remember it." Now Watson, using somewhat more moderate language, said, "Well, I don't want him around me. I won't bother him if he keeps away from me. I can't stand anyone around my bunk." Then, revealing perhaps the basic problem, he added. "If a corpsman would come and put his arms around me, I'd jump and I might strike him." Again I interrupted to reinforce my order, "No one manhandles anyone on this ward. There's a difference between wanting to hurt someone and hurting him, between thinking, saying, and doing."

ATTENDANCE AT MEETINGS

The community meetings were so essential a part of the therapeutic process that we were not permissive in the matter of attendance. All patients were *expected* to attend. This was a basic tenet on the ward. When patients deserted the meeting in fact or fantasy (except in unusual circumstances), efforts to bring them into conformity took precedence over everything else for the moment.

Reading Magazines and Playing Solitaire. One problem which often presented itself was that of dealing with the patient who read a magazine or played solitaire at the start of the meeting or during it to indicate that he was taking no part in the proceedings. "Psychopaths" of the aggressive type often behaved in this way, especially at their first meeting on the ward. Since such conduct was an open gesture of defiance and contempt, it had to be confronted directly. But both the moment and the

manner of confrontation had to be carefully chosen. I made it a practice to wait until a moment when the discussion was going along well and the group were clearly in rapport with me and with each other. Then I would stop, often in the middle of a sentence as if I had just noticed what this one patient was doing, and I would turn and address myself to him directly. I would speak firmly, careful to avoid evidence of anger, pique, or intention to single him out for ridicule. I implied, rather, that I was curious as to why he was behaving in this manner, and displeased, implying also that by his attitude he was committing an act of courtesy which the rest of us would not be guilty of toward him.

In one fairly typical instance, an extremely aggressive schizophrenic sat reading a magazine and noisily flipping the pages while the meeting was in progress. At an appropriate moment I asked him, "Why are you reading a magazine?" An apprehensive silence descended upon the group, for he had previously expressed open contempt for the whole idea of the meetings. "Because I want to!" he snarled. Everybody was looking at him, and he now put the magazine on his lap, adding, "Because I don't want to be part of the group. I'm not interested in anybody else's problems—only my own." I said, "Well, while you're on the ward, we expect you to be part of the meetings even though you don't talk, and you can't be a part if you are reading." He now threw the magazine down in a sort of defiant compliance and half turned away from me. But he listened. He listened in silence in all the meetings while he was on the ward, and only on the last day did he show how much he had been part of the group; while the whole group had egged on a fellow patient who had "made fun" of a psychotic officer on the ward, he stood up against them and denounced their behavior. They were stunned; what is more important, their unkind behavior ceased.

Playing solitaire was usually a more open sign of contempt than reading a magazine, for it required a more active isolation from the group. In one meeting a patient with an aggressive character disorder sat on his rack playing solitaire. When I asked him why he was doing this, he answered that he wasn't interested in the meeting and wouldn't discuss his personal problems. This

open defiance could not be ignored, so I asked him to put the cards away. He defied me: "I don't want to put them away." There was a moment of tense silence while patients and staff watched him anxiously. I waited patiently, watching him, telling him by my actions and not by words that this sort of defiance toward me was not permitted. Then, after flipping down a few more cards, he put the deck in his pocket and lay on his bed looking at the ceiling. The group turned back to business.

In the next day's meeting he again went to his rack and, tossing the cards down, began playing solitaire. When I asked him to return to the group he said, "I'm thinking." I told him, "We don't play cards in the meeting. There are certain rules on the ward and courtesy is one of them." At this he turned in such a way as to conceal the cards from me and continued playing. I walked over to him and said, quietly but firmly, "We treat you with respect and we expect you to treat the group with respect." He slammed the cards down angrily. Thereafter, though perhaps he was present only in body, he did not play cards during the meetings. The principal reason for this was the fact that he found no open allies in the group. Moreover, the secret wish of the group was for the power of the officer to control unacceptable impulses, and he symbolically stood for theirs. Certain acting-out was not allowed because of its "infectiousness" and its demoralizing features.

The rule in regard to defiant gestures of this type is simple: Wait until the appropriate moment; confront the patient in a comfortable way; pursue the matter to the point at least of compliance with the ward's basic philosophy of behavior. The patient who is acting in this manner is usually a newcomer, making his way with fear and anxiety, and wanting to belong if belonging can be made safe for him, wanting to establish himself in a special status in the group. If he is forced by social pressures to conform, his anxiety and fear will be less troublesome to him than if he is permitted to carry out his defiant behavior; and he then has the face-saving excuse that he has joined the group because he was "made to" and not because he wanted to.

Deserters from the Group. Some patients simply walked away—

went "AWOL" from the meetings. In a few instances these were intensely withdrawn schizophrenics who fantasized that some danger menaced them in the group and who walked (or sometimes ran) away in fear. Often they were the markedly paranoid people who withdrew in a belligerent and rejecting way. At other times they were confused, disoriented psychotics who just wandered off and only had to be led back.

Such withdrawal was a less defiant gesture than that of the patient who read a magazine or played solitaire. It was felt, however, to be antitherapeutic in its effect, and every effort was made to return the "deserters" to the group. When a patient left the meeting, either a corpsman or a nurse would follow him after a minute or so and try to persuade him to return. If their efforts failed, I would leave the group and talk to him for several minutes if necessary while the meeting went on without me. Usually he could be led back, either by the staff member or me.

On this matter, though we were not permissive, there were occasional exceptions, dictated by common sense. In one instance, for example, a patient was a diagnosis of neurotic anxiety reaction became visibly tense in his hostility toward a schizophrenic who was "acting crazy." Finally he got up and walked to the solarium, obviously in fear that he was going to lose control. A corpsman stood up at once to follow him, but I stopped him with a gesture of my hand, saying so that the group could hear, "No, let him stay there for a while. He's very tense.—he'll come back soon." The group clearly understood why he had left, and I would have acted contrary to their expectations if I had forced him to come back before he had got control of himself. A few minutes later, since he had not returned, I walked out to the solarium and asked if he couldn't come back now. He readily agreed and returned with me, his tension now under control.

Throughout the 10-month period of the therapeutic community only 2 out of the 939 patients on the ward during that time refused to attend the meetings; and both of them, in their retreat at the far end of the ward, were observed to be listening quite intently to what was being said by the group.

FIRST VERBAL COMMUNICATION

Who first spoke in the meeting and what he said were important, for the initial verbal communication often set the tone for the hour as a whole. If this was some comment thrown out just to get the ball rolling, it seldom aroused much response. But if it was a meaningful and genuinely felt communication, it was likely to usher in a highly therapeutic hour.

In the first few meetings on the ward the initial communications seemed to be almost all questions or complaints about practical matters, and the discussion was almost totally concerned with such matters. One of the advantages of the daily meetings, of course, was that feelings of resentment about the inconveniences and irritations of hospitalization *could* spill over instead of building up to the point where some emotional outburst was inevitable. But the meetings were also to bring out into the open the deeper and more meaningful anxieties for which the practical complaints were often only a cloak. For the most part I made it a practice either to ignore the purely administrative type of question or to ask the patient to take such matters up with me in individual interview. If the questions persisted, I tried instead to bring the discussion around to the emotional problems underlying these questions. Gradually the meetings came to be concerned more and more with the deeply meaningful thoughts and feelings that occupied the patients' minds in relation to their illness and their social community.

Schizophrenic patients frequently made the opening communications in the meetings, and they commonly preceded these initial remarks by a request—"May I speak?" or "Is it all right for me to speak about how I feel?" This approach almost seemed a schizophrenic hallmark, as if the schizophrenic were requesting the right to belong and also expressing the need to relate himself first in a one-to-one relationship with the doctor before being able to take the next step in relation to the group, an approach involving the problem of identification and the relegation of social omnipotence to another.

The schizophrenics also frequently put their opening communication itself in question form; for example, "Why do people deprecate others without good reason?" or "Why do people spit

on food in the galley?" But sometimes an acutely disturbed schizophrenic would stand up and give a terse statement of his problem without any initial query. One patient, for example, began a meeting by saying, "I want to get out of the Navy and be discharged!" It was usually only the schizophrenics who introduced their feelings about the Navy in a direct and simple communication of this sort. The patients with aggressive character disorders, who had acted most strongly about this matter, commonly waited until some other patient had expressed a belligerent attitude toward the Navy before they came out with a direct comment, and then it was one in support of the original speaker. The explanation probably is that their comments were so castigating that they got little support from the others, who usually mobilized to the defense of the Navy when it was so harshly attacked, but they reached a point where they could not withhold their hostility. It was going to be words or deeds; in the therapeutic community only one was socially sanctioned.

One meeting began with a categorical statement from a schizophrenic, "The Japanese want peace." It was only after the meeting that I learned the meaning of this, when the Korean resident doctor on the ward told me, "What he means is that there must be peace between him and me. His mother told me that I scare him, and I notice that he watches me all through the meetings and that he wants to shake hands with me often." The Japanese were really one Korean doctor.

SILENCE

Psychiatrists have long understood how significant is silence in psychotherapy with the individual patient. But silence in a community meeting of 15 to 34 patients plus 5 to 10 staff members is a phenomenon that is not yet so well understood. Its significance remains to be studied and established.

In an absolute sense of the word, of course, the community meetings were never silent. There were innumerable sounds on the ward—the echoes of traffic in the nearby street, the ringing of the telephone, the shuffling of feet, the cracking of knuckles, coughing, sneezing, clearing of throats. When I speak of silence in the meetings, I am not speaking of the absence of these sounds,

but the absence of verbal communication.

In this sense of the word there were often prolonged silences in the community meetings. Sometimes the meeting began with a period of silence, after which the group broke into discussion that continued uninterruptedly to the end of the hour; at other times, periods of silence recurred intermittently throughout the hour, sometimes dramatically preceding or following a particularly significant communication; and in two instances the hour was spent in almost total silence. A period of silence cannot be dismissed as an empty hiatus in the therapeutic process of the community meeting. Silences were themselves a part of this process and analyzable as such.

For different members of the therapeutic community the periods of silence had many different meaning and uses. But for all, including the leader, they were moments of a special form of self-control. The meetings in which there were no more than brief periods of silence were often, in fact, meetings in which one member of the group could not tolerate silence. For example, in one group there was an extremely ill schizophrenic who talked whenever there was a moment's pause. A neurotic patient said of him, "He only feels comfortable when he's talking."¹

I learned early in the experiment that silence had significance as nonverbal communication and that it should not be interrupted merely for the purpose of filling the void with words and doing away with silence. With rare exceptions I did not call on patients to speak. There was no premium on talk and no premium on silence; both were grist to the mill. I did, however, occasionally direct the thoughts of the group to the meanings of silence.

1. In another series of meetings a very bright patient, Newton, with a neurotic anxiety reaction, talked excessively on a high intellectual plane using many psychological terms. He had previously had some outpatient psychotherapy elsewhere. When a patient suggested that he was talking a lot, he acknowledged that it hadn't always been that way. "When did it change?" someone wanted to know. He thought at about age 7. "Why then?" he was queried. Perhaps it was because at 7 he had had his tonsils out, he said. His parents told him one morning that he was going to see a doctor. They hadn't mentioned it before nor did they tell him why, though he had previously seen this doctor about his tonsils. When he arrived at the doctor's office they were ready to operate on him and he soon found himself held down and screaming while he was anesthetized.

The initial "communication" in the meeting was frequently silence as in a Quaker meeting; it lasted as a general rule about 5 minutes, but occasionally much longer. Usually this was a comfortable silence, as if we were sitting together in the theater waiting for the curtain to go up, or in solemn meditation. When the ward was full of acute vocal disturbed patients, it was a surcease of no minor value. But some patients, particularly in their first meeting on the ward, were made extremely uneasy by it, even when it was short. Sometimes it also made me anxious.

When the silence was unusually long, I could not always determine whether the patients were giving me the "silent treatment" or were remaining silent to avoid the discussion of painful material or whether there was some other explanation. This was usually clarified for me by what was ultimately said, but sometimes it was not clear until the following day's meeting or in the afternoon's "feedback."

Sometimes the patients tried in a number of ways to get me to talk. In one meeting, for example, after a rather long initial silence, they pointed out that another psychiatrist had always given them "answers." One patient cited an answer he had been given on child-rearing and asked me, "Would you agree with him, Doctor?" It was my impression that they were having difficulty in using the group to discuss emotional problems that were meaningful to them and that they were somewhat resentful toward me for bringing them into this difficulty. They wanted me to prime the pump or convert the meeting into a question and answer period which was safe with its clear roles and structure. Since I did not perform on demand for them, the

"Strange about your parents not telling you," I commented. Then a patient in a moment of startling insight added, "Yeah, they gave you the silent treatment." So instantaneous and so revealing was this interpretation that Newton's obsessive talking dramatically diminished at this moment and did not recur during the remainder of the meetings while he was on our ward. For the first time he had put these things together, not in terms of the operation, its castration meaning or the intellectual association, but with the emotional catastrophe of his parents' failure to explain to him when they knew that something "terrible" was going to happen to him.—hence Newton came to the conclusion, as he told me later, that silence was a dangerous thing to him and he had to talk anxiously to find out if something was going to happen to him and also to keep it from happening.

problem of dealing with the anxiety which my silence might arouse in them was left strictly in the community's collective lap. It was interesting that, in the next meeting, which began with 10 minutes of silence, a very aggressive "psychopath" turned to a schizophrenic patient and said, "Say something! Get started." The schizophrenic patient complied, and soon most of the patients were talking freely.

The reluctance to discuss "personal" matters was often expressed as a reason for remaining silent. In one meeting, after an initial silence of 12 to 15 minutes, a neurotic patient turned to me and said, "Can you tell me what all the silence is about?" Then another patient broke in, expressing resentment at having to attend the meetings and announcing, "I am not interested in other people's problems."

I said, "But you belong here in the group, and I suspect that deep down you don't feel that way at all—that you are interested in other people and want others to be interested in you." (I knew this from interviews.)

"Well," he conceded, "maybe deep down."

"Maybe not so deep down?"

"Perhaps. But I understood from you that our attendance is not required."

"You misunderstood," I replied. "I expect you to be here, but you don't have to talk if you don't want to."

But he did talk then and he talked a great deal about his personal problems. He ended by saying, "I need help." His communication began an active discussion of these problems that continued through the rest of the hour.

The longer the initial silence lasted, the harder it probably became for a patient to take the initiative and be the first one to speak, and yet the more urgent it seemed to break the silence up to a point, beyond which it seemed as if silence had descended and was "the order of the day." Such a point was felt in several meetings. It was a sort of "second wind" of silence.

In one meeting, where it was apparent that the patients wanted to talk but everyone hesitated to make the start, I discussed the problem of silence in terms of "Who talks first?" touching upon the factors of shyness, self-consciousness, and pressure that

enter into it. However, there were no takers; I believe, in fact, that the attention which I drew to these factors tended to make the patients more self-conscious. I later found that more general discussions of silence that did not tend to put the finger on the first to speak were more effective.

For a period of time the meetings were characterized not only by the fairly customary initial silences, but by long intermittent silences throughout the hour. These silences had become almost a conscientious thing, as if the men thought that the ward culture demanded it of them. In our staff discussions of this problem, the head nurse made the interesting observation that, on the past two days, the patients had not moved my chair back between the beds at the close of the meeting, as they had invariably done before. It was almost, she thought, as if they felt that the meeting was not over, that there was unfinished business for which they wanted me to remain.

In one community meeting only one patient uttered a single word. To discover the reason for this totally silent hour, it is necessary to consider some of the circumstances of the previous day's meeting. First, since a large number of transfers had just been made, only 12 patients were now on the ward, and they were outnumbered by the 14 staff members and visitors at the meeting. Second, the discussion dealt with the question of leadership and touched upon both doctors and officers, with some hostility toward both. Third, the word "homosexuality" was used in the meeting.

These circumstances probably accounted for the determined silence that characterized the next day's meeting. After 20 minutes of silence, I discussed silence in terms not only of words, but of thought, referring in this connection to a schizophrenic patient in the group who had gone over the fence after yesterday's meeting and had wandered confusedly a few feet away before he was returned to the ward. I pointed out that this patient, who had been silent in yesterday's meeting, had told me later that he thought he should have talked.

The patient himself now spoke up, "I was afraid." I asked why, and he answered, "I don't know." I asked if anyone could help him. One patient began to wring his hands and another

put his hands over his face, but no one said a word. I looked at the patient who had spoken and who, I believed, wanted to talk, but he dropped his glance as if he felt guilty.

Nothing more was said. Possibly their silence was a sort of conscious or unconscious conspiracy stemming from their resentment against the doctor (carried over from the theme of yesterday's meeting), their resentment against the staff which had outnumbered them, and their fear that the dangerous subject of homosexuality might be raised. But if this were the case, I felt that so long as I left their silence as their own production, they would be caught in the meshes of their own anxiety and feelings of guilt about it. The gist of my summary of this hour was, "I don't know what the silence is about because you don't tell me. But the hour is yours to use as you want."

While this worked quite satisfactorily, I think, however, that it is a precarious matter to let an hour run in total silence, and probably better devices than the above can be developed to cope with this. After all, not two people are involved, as in an interview, but thirty to fifty people. It is a social anachronism which I do not clearly understand.

AFFECT: LAUGHTER AND TEARS

Laughter. It probably goes without saying that a sense of humor is a mark of an integrated and healthy person and that the ability to laugh at appropriate times is essential for mental health. But laughter also has its function in the balance of the mental patient's emotional life. There were countless moments of it in the community meetings, a few of which will be described here to illustrate the types of situations in which it most often occurred.

Since much of wit is aggression in a socially acceptable disguise, it is not surprising that laughter was often heard on the ward. Here the wish to injure was frequently quite intense but the ward culture required that it be sternly suppressed. Laughter enabled the hostile impulse to express itself in an acceptable manner which relieved the common tension in the group and served to balance the economy of internal tensions in the individuals.

This use is seen in the following example. A patient complained in one meeting that he had a pain in his abdomen and said, "I want something for it." Since I did not comment or offer to give him "something for it," another patient came to his support with an innuendo obviously directed at me, "We are not doctors." Then a third patient prescribed jokingly, "Take Tums." This was met with a quick burst of laughter.

The prescription here by the layman, doing his best for the sufferer by means of his "billboard education," is not only a veiled hostile reference to the doctor, but it also depreciates the complainer by reducing his "abdominal pain" to a laughable tummy ache. The situation of frustration and hostility is thus turned into a humorous one at the expense of both the doctor and the patient.

Perhaps hostility also explains the laughter which followed another patient's account of a dream. "It was a crazy dream," he said. "It was about Dr. Jones" (a ward medical officer in the hospital). The group laughed uproariously, not at the dream, but at the association of the words "crazy" and "doctor."

Sometimes the witticism was directed at the situation of being in a mental hospital. The routine letters which the hospital sent out informing the next of kin that the patient was on a psychiatric ward always caused the patients considerable anxiety, and came up frequently for discussion until the practice was discontinued. In one meeting where they were being discussed, a patient said that his mother-in-law was listed as his next of kin and that when she got the letter she would say, "I told you so." There was laughter at this, so another patient tried his hand at a joke. "The letter will say," he caricatured, "Your son is in the nuthouse." But no one laughed at this. This "joke" unmasked the humor by crudely spelling out what the patients feared would be the interpretation given to the letter. Then after a moment's silence, another patient said quietly, "Well?" Now there was loud laughter. The witticism here expresses a rather wry acknowledgement of the current situation. What is finally admitted is, "Well, this is the case, is it not?" and once again the humor is created by reversion to an oblique understatement, by recoding the whole message in one ridiculous word. In brief, this is the kind of witticism which helped the group to accept

their status as mental patients, one of the major problems of acculturation in the mental hospital. Such a joke, it is true, would have been impossible if the anxiety on this score had not already been partially mastered in the previous meetings of the group, and if they did not feel somewhat friendly towards the staff.

A similar instance occurred in a meeting where a "psychopathic" Marine was acting the role of a visiting sniper who did not really belong to the group. Another patient, with an obvious reference to the Marine and to the popular view of the Marines as the "elite" of the military service, said, "If you were all right you wouldn't be in this elite group." This remark evoked considerable laughter, and it had a distinctly leveling effect on the patients who acted as if they didn't belong. Its inverse humor, however, was doubly meaningful for here there was a special form of *esprit de corps*.

Sometimes the laughter was in response to an insightful comment by one patient about another patient's behavior. Such a comment, humorously phrased, usually had infinitely greater impact on the group than any comment from me would have had. In one meeting, for example, the group were discussing a manic-depressive psychotic whose behavior had almost made chaos of the previous day's meeting. On the day which I am describing, he was off the ward taking psychological tests, and the group spent a considerable part of the hour trying to understand his irrational conduct and put into words their feelings about him and the great anxiety which he had aroused in them. Suddenly one of the patients, also a manic-depressive, summed it all up for them, "This guy leads you on and then leaves you." The laughter which greeted this insightful comment, with its humorously stated sexual implications, changed the whole tone of the meeting. It was as if he had "pegged" the situation and now they could have a beginning on a mutually agreeable "joke."

In many instances such as I have described, a sudden burst of full laughter served a group process of relieving tension. Not infrequently it occurred at crucial points in the meeting where verbal communication had reached an impasse, and the relief which it brought allowed the group to move on with more

freedom and relaxation.

But there was also at times tense and uneasy laughter which did not serve this purpose. I made no direct reference to this type of laughter except when there was danger that a seriously psychotic patient might misinterpret it as ridicule of him or when it was grossly inappropriate. In one group, for example, there was a mute, catatonic schizophrenic whom the other patients feared and whom they referred to behind his back as "the Zombie." Near the close of one meeting, during which he had been wandering about without any of the group paying much attention to him, he came at my invitation and seated himself in a chair beside me. At this a tense, uneasy laughter broke out in the group, who were watching me closely for any evidence of fear. I assumed a puzzled look and asked as if this conduct didn't make any sense—"Why do you laugh?" There was no answer. But for the schizophrenic patient the question now answered itself. Since nobody had replied, obviously they were not laughing at him. Perhaps they were laughing at nothing at all, or perhaps at their own fantasies, as he did. But I had at least by implication identified the laughter as inappropriate.

An inquiry into the reason for inappropriate laughter sometimes led to rather revealing comments. In one meeting, while a Marine sergeant was speaking seriously of serious things, two very sick patients burst into laughter. Another patient reproached them, "You are being discourteous. You should not laugh when a man tells his story." I supported this criticism by saying, "Yes," and looking toward the patients who had laughed. They made no response, so I added, "You owe us an explanation."

One of them now replied, "I feel the same way as the sergeant, and when he speaks he makes me laugh. I came to the hospital with him and we were laughing at each other all the way."

"It doesn't bother me," the sergeant replied.

"I laughed because I can't help but laugh," said the second patient who had laughed.

"We sometimes laugh because we cannot tolerate our feelings," I explained.

"I laugh so I won't cry," he said.

After this, there was no more laughter.

There was always, of course, the secret and personal laughter of the hallucinating schizophrenic. This type of laughter, however, was isolated as a pure symptom and was dealt with in the group only if necessary to explain his social behavior. For example, a schizophrenic patient walked out of one meeting and lay on his bed. A corpsman followed him and I called to him, but neither of us succeeded in bringing him back. Later, when he had returned to the group on his own initiative, he began to laugh. I asked him what he was laughing at and he said, "At you." He refused to elaborate.

The "comic situation" had its most dramatic example in the hebephrenic in his guise of the clown. But this was a role that did not bring responsive laughter. In conventional life we laugh at the clown and love him because his ridiculous antics give us a comforting sense of our own superiority.² In the mental hospital the clown arouses quite a different response. He keeps before the eyes of the less seriously ill patients an exaggerated pantomime of the very thing that they fear they may (or have) become. And, by intensifying their deepest fears of insanity, he arouses a strong hostility in them. To deny their own fear, they are eager to convince themselves that he is "putting on an act," and they want him to be punished for it. The hebephrenic patient in the role of the clown, therefore, presented a problem with which the therapeutic community found it very difficult to cope.

One such clown on our ward will be briefly cited in illustration. Just after one meeting began, a colored patient suffering from a hebephrenic type of schizophrenic reaction ran into the meeting, his eyes wide in mock excitement, his face covered with a white cream—clowning and making ridiculous movements and gestures. I had not previously seen him as he had been admitted since I had last been on the ward.

2. On a deeper level the clown represents the tragic impotent father-figure, totally depreciated. Moreover, he seems out of place in a therapeutic community since he is a one-man show. Historically the clown in medieval times stood for the laughter of the well and whole at the cripples, the mutilated, the midgets, the idiots, the blind and deaf, the poor and the insane. One could hardly expect the reenactment of Bedlam to be funny on a psychiatric ward. It is the gross social inappropriateness that robs the schizophrenic clown—of which we had a number—of his power over this audience. When people gather and can effectively express themselves in words, only the most skillful and sophisticated clown can avoid arousing guilt, hostility, and embarrassment.

For a day or two his behavior had led the other patients to hostile acts towards him. With the license of his insanity he had treated them in what seemed to be a caricature of the way white men sometimes treat colored people. He ordered them, he showed contempt for them, and was altogether arrogant and condescending toward them. Moreover, his make-up was a part of his mockery. When I told him to sit, he cowered and shook in clowning mock fear; but when he was unmasked by an interpretation of his behavior, his clowning slowly subsided. Within days, his delusions of grandeur came down close to earth and he was able to relate comfortably to others and talk reasonably (for such a sick schizophrenic) in the meetings. I saw him in addition to the meetings in brief daily interviews. He developed intense feelings toward me. But his clowning, which angered rather than amused the patients, and which was almost a caricature of the stage insane character, led the others to accuse him of putting on an act. In time they came to an area where they could meet: he relinquished the clown role, and they accepted the severity of his mental illness. Though he still talked most inappropriately, he now found company, who did likewise.

Tears. Crying was usually considered in the community meetings as a physiologic expression of an emotional response to the matter being discussed, differing only slightly from other types of emotional expression such as sighs, trembling, or laughter. In the military culture from which the patients came, to "break down and cry" was fraught with great conflict. Thus the tacit assumption that it was all right to cry in the presence of other men epitomized the freedom of emotional expression that characterized the therapeutic community.

The subject of crying was discussed in a number of meetings. On one such occasion, when a patient confided to us that he had gone into the head and cried because he so much wanted to hit a patient who was behaving very disturbingly on the ward, another patient said, "It's a sign of weakness to cry." But most of the group took the opposite view. After his single remark on the subject, the patient who had condemned crying took no part in the discussion. So I turned to him and asked him whether he

ever cried. He replied very positively, "No." I then asked whether he had ever seen his father or mother cry, and he said, "Yes, I've seen them both cry. But in their case there was a reason." He paused and modified his first dogmatic statement, "You have to evaluate the reason before you know whether crying is weakness or not." In summarizing the discussion at this meeting, I dealt primarily with the question of the discharge of feelings, whether by crying or by acting the clown.

A number of times, men cried openly in the meetings. For example, at one meeting a sergeant with a highly distinguished combat record, whom all the patients deeply respected, told the story of the circumstances under which he had been deprived of his platoon. After a moving speech, in which he addressed the group almost as if it were his platoon, he fell back into his chair and burst into tears. There was a long silence while he wept. Then, when his crying had ended, he said, "I feel better, I feel better."

On some occasions, however, I forestalled a patient's crying, particularly when the moment in which he threatened to break into tears was so close to the end of the hour that the matter could not be adequately dealt with.

STAFF LEADER TECHNIQUES

Interpretation. The nature and timing of the leader's intervention in the meetings should be determined by the purpose for which he intervenes—to direct the discussion in a way that will further the patients' understanding of themselves and their problems. To achieve this purpose, his interpretations must be aptly timed, simply phrased, relatively short, and usually spoken in a friendly tone. The manner in which they are made is often more important than what is said.

In the community meetings at Oakland I made it a practice not to interrupt when the discussion was progressing steadily except occasionally by a comment designed to draw the patients out on some meaningful point. This interruption was usually a repetition in question form of the patient's own words. For example, if he had used the word "friend" when it told only part of the story, I might intervene to ask, "Friend?"

In taking a position that was at variance with what a patient was saying, I often used a similar approach, but stating my feelings. If a patient was denying a feeling, for example, I would comment, "Deep down you don't feel that way really; I wonder why." This would usually lead to a closer examination of his real feelings. And when a patient told us how he idolized his father, at the same time telling how cruel his father had been, the contradiction between his two statements did not need to be dragged accusingly out into the cold light of reason. It was enough to say wonderingly, "Isn't it strange that you idolize your father?"

Thus my comments frequently took a tentative and questioning form:—"Doesn't that strike you as strange?" "Perhaps it could be." "I wonder if that is the case." "Could it be that . . . ?"; "I have a feeling that . . . " or "Isn't it possible that . . . ?"

The type of questions conventionally employed in history-taking, such as "When did you first feel this way?" or "Can you tell us about your childhood?" were asked only rarely when the answers would be helpful to the group in the current situation, and never to satisfy my own curiosity or to help me fill out my own impression of the development of a neurosis or psychosis.

Occasionally I would refer a patient's comment or question back to the group, saying, "I wonder what the group thinks," or "Can anyone help him?" But I think that this technique should be used sparingly and only at clearly appropriate moments. If overused, it not only fails in its purpose, but is also likely to be resented and mimicked by the patients, particularly if it becomes a conspicuous repetitive device. Stock questions bring stock answers.

In many instances I directly interpreted a patient's communication. For example, one patient told us that he heard voices saying, "We are going to hang you. There's a hanging party after you." I pointed out that the only hanging party was within himself and that his imagination was playing a harmful trick on him. He seemed to get the idea, and said he thought this might be true.

But the significance of the patient's communication was sometimes so clear and complete that commenting on it, I felt, would be unnecessary. In one meeting, for example, a schizophrenic

patient called another patient who had helped him "Smith." Since Smith was not the other patient's name, the charge nurse on the ward asked him why he had done this. His explanation was, "Mr. Smith was a friend of mine when I was a child, and he gave me a nickel once after my father beat the hell out of me. I've never forgotten people who are kind to me, and that's why I called him Mr. Smith."

Sometimes, too, another patient's comment on a communication made to the group was an interpretation upon which I could not possibly have improved. In one such instance a patient who had been deserted by his parents in infancy told a story about "a little boy who ran away," which was his life story in reverse. The boy in the story ran away because his parents were cruel, though on the surface they seemed to be loving. The terrific rejection of the child by the parents was summed up with profound impact by another patient, who said, "They were lousy parents." Nothing more needed to be said, and I was silent.

Sometimes I raised a specific question for the group to think about or define, such as, "What is silence?" or "Why is one angry?" or "What is a gentleman?" And on a few occasions, when the patients asked me for information on some specific subject which was appropriate to their emotional difficulties, I gave a short and simple talk on it. But I never indulged in statistics, psychiatric jargon, citing of the literature, or authoritative answers to "information please" questions.

During the last few minutes of the hour I summarized the discussion as I saw it, taking first the manifest and then the latent content but dealing with it first on a social and then possibly on an individual or group ego level. On some occasions, when I was not clear as to what the theme had been, I said so. And then we would begin again the next day.

Comments on Behavior. Some of my comments, of course, were directed toward matters of behavior. I occasionally said, "Stop it," "Sit down," "Come join the group." Once I said, "Even though we (sic) act crazy, we don't behave like that!" which had telling effect. So also did an occasional clear parental type of comment such as, "We expect better behavior from you." No threats were either stated or implied; the emphasis rather

was upon what was proper conduct in the therapeutic community—"We don't do that type of thing here."

When patients were talking psychotic nonsense, it was sometimes sobering to say, "That doesn't make sense," or "That sounds really mixed up," or even, as I did on one or two occasions, "Come down to earth." Many times a gesture, without words, or a simple statement such as, "You're not really quite yourself," or "I (or they) think you are confused," was enough to restrain a person who was behaving disturbingly or threateningly.

(I am speaking here about the ordinary course of events in the community meetings. In instances of flagrant defiance of the rules of ward decorum, as I have explained earlier, I issued firm commands, and the effort to bring the defiant patient into compliance took precedence over the direction of the group discussion.)

Unanswered Questions. No attempt was made to answer all questions that were addressed to me by the patients. If a question was appropriate to the purposes of the group, I answered it. Otherwise I was silent. At times I openly admitted, "I do not have an answer." It is essential, I believe, for the leader to be on guard against accepting the role with which the patients may endow him of an omniscient or clairvoyant power. He is a human being who is often limited in his understanding to the small periphery of what he sees and hears, and he must not hesitate to say so. In my summary of one meeting I baldly stated, "There are no answers to some questions." This had a profound, almost electrifying, effect on the patients (and on the staff). It shattered their illusion of the omniscient leader.

I did not answer practical questions of a purely administrative nature which were of no significance to the purpose of the meeting. When such questions were asked, I was either silent or I told the patient to take the matter up with me at the appropriate time and place—either at sick call or in individual interview.

I was silent, too, in response to provocative questions or to questions in which I perceived a hidden intention to divert the group from its therapeutic purposes by introducing an intel-

lectual topic of discussion or by putting me in the position of a lecturer.

In one meeting, for example, when we were dealing with a schizophrenic patient who was mute, another schizophrenic said to me, "Have you had many cases like this, Doctor, or is he unusual?" I did not answer, though he must have detected a moment's hesitation as I decided whether I should or not. He said, "If this is an inappropriate question, I will withdraw it." The formal almost legalistic phrase led me to say, "The question is not inappropriate, but I don't think it would be particularly helpful to answer it."

When diversionary questions were brought up at the end of the hour, I usually said, "Our time is up. Why don't you bring this up tomorrow?" On one occasion, after I had concluded my summary, a patient asked, "What do you do for sleepwalking?" As I had already said, "The meeting is over," I simply left the group without replying. The patient, I found out later, felt disappointed and somewhat angry but not particularly rejected because, as it turned out, he was consciously testing me out to see whether he could make the hour run longer than I said it would. (On some occasions, however, hours were permitted to run overtime. Such decisions, while sometimes wrong, were deliberate and yet instinctive.)

Inevitably, the refusal to answer questions caused some frustration. In one instance, in which I was probably in error, a schizophrenic patient to whose question I had not replied, burst out, "You think I'm a nobody." But, in general, it was not a part of our technique that we had to reduce anxiety wherever it occurred, any more than that we should give a patient a sleeping pill if he had not slept for a night or two. We believed, rather, that patients could deal with their anxiety and could use it, with what help we could give them, to worry through to a solution of their problems. The philosophy of the ward was, therefore, not a tranquilizing one, but one in which the patients were forced by circumstances to face reality, to face their feelings, to face each other, and to face themselves and the socio-environmental situation.

Practices On Seating. Each patient brought his own chair from

beside his bed and placed it in the position where he wished to sit. Since we wanted the seating to remain a spontaneous expression, the choice of position was only rarely referred to in the meeting by me, and the patients were not directed to any particular position. If patients were standing or sitting on the floor, they were asked to take a chair; but they were not usually told which chair to take. On one occasion a patient took the position in which I invariably placed my chair, and when I walked toward my place I found it preempted. I sat nearby. Throughout the hour he sat quietly in my place, listening to everyone conscientiously and clearly imitating me.

We often wondered what would have happened if we had arranged the chairs prior to the meeting in some configuration of our own choosing. But that would, of course, have changed the whole matter and would have deprived us of a significant form of nonverbal communication.

Introduction of Visitors. Many psychiatrists and psychologists from outside the hospital came to sit in on the therapeutic community meetings. Their visits were valuable to us, both in enabling us to use the ward experiment as a teaching device and in giving us the benefit of their observations. On the other hand, the presence of visitors (especially civilian visitors) inevitably introduced an element somewhat foreign to the ward and, on occasion, interfered with the ongoing process.

At times, particularly if the visitors were sensitive, interested, and sympathetic, the patients took a certain amount of pride in demonstrating their sophistication and cooperative venture. At other times, however, they were suspicious of visitors; then they tended also to show a sense of distrust toward the staff—a feeling, born to some degree of jealousy, that we were not genuinely interested in them but were merely seeking something for ourselves or to show them off. This was especially true when there were a great many paranoid schizophrenics and aggressive "psychopaths" on the ward.

One such meeting in the early days of the experiment was almost a demonstration of what a community meeting should not be. On this occasion I had postponed the meeting for an hour awaiting the arrival of a distinguished visitor. As a result, it was

an extremely difficult and turbulent one, for the patients saw the postponement as evidence that someone else—and a civilian visitor at that—took precedence in my eyes over them and their routines. Repeatedly throughout the hour they asked that the meeting be disbanded until the next day, a thing which never happened at other times.

In this meeting I made a second error, never again repeated, of introducing my visitor to the group simply as "a friend of mine," without explaining who he was, where he came from, or why he was there. Matters were further complicated by the fact that he had brought a second visitor with him. So the patients were being asked to perform not only for my friend but for my friend's friend, and they had little intention of doing this. To compound confusion, since the two visitors were father and son, the patients heard me address both of them by the same name. This was extremely disturbing to the severely ill schizophrenics with ideas of depersonalization and confusion of identity (and the previous day one patient had struggled with the idea that I might be two people instead of one).

Through a process of analyzing this and similar errors in procedure with the aid of the staff, we worked out certain rules governing the introduction of visitors to the group: In presenting a visitor I told the patients precisely who he was, what he did, and where he came from, and explained that he was here to attend our meeting.³

3. I never asked them for permission for the visitor to attend after I did it once in the early days of the community and saw immediately the inappropriateness of this pseudo-democratic gesture disguised as a social amenity. After all, what could they say? And my query would set the tone of the meeting and give undue weight to a matter which was an administrative one that, in the final analysis, lay in my hands. The truth of the matter is that this therapeutic community was not a democracy in any political sense and we practiced no concealment of this fact by vote taking or consensus polling on administrative matters. Indeed it is my belief that much confusion in all forms of "group therapy" rests with just this factor, and I know of innumerable examples of highly rationalized sets of mind which group leaders have evolved to carry on an illusion of "democracy" and "permissiveness," when there is clear direction exerted in subtle and not so subtle forms. Since decisions about their social, administrative, and therapeutic welfare rested in my hands, it was up to me to act and to subsequently modify any erroneous actions; and this responsibility could not be abdicated. Moreover, "groupocracy" is sometimes an inappropriate carryover of the pure laboratory, nonoperational group dynamics research, a procrustean theoretical bed upon which to fit therapy.

Usually visitors were taken to sick call and introduced to each patient individually before the meeting. Whenever possible, also, they were expected to come for two consecutive meetings.

When these rules were adhered to, and when there were not too many visitors at one meeting or on too many consecutive days, the interference with the community process was negligible, and some visitors made extremely penetrating contributions to the discussion, both at the community meeting and at the following staff meeting.

Use of Phonograph Records. Phonograph records were occasionally used in the meetings to stimulate discussion of a specific problem before the group. For this purpose we used primarily a series of records which I wrote and had professionally produced, which present brief stories in short dialogue form of conflicts between parents and children.⁴

Each of these stories ends on an inconclusive note, without resolving the conflict, leaving the listener to imagine the outcome for himself, as a sort of dramatic unfinished sentence exercise. So there are as many endings as listeners, depending upon the feelings and thoughts which each one brings out of his own life experience to the present situation.

The playing of a record tended to unite the patients on a common topic that displaced present conflicts into childhood, which was on occasion simpler to deal with than the highly charged here and now. A properly selected record sometimes

4. The 16 dialogues in this series were developed originally for use in group therapy with tuberculosis patients. They are available on two 12-inch records, and the text is in book form (Wilmer: *This is Your World*). It is not suggested that these are the best records, but only that they are available and that there has been some experience with their use. The range of topics represented is sufficiently broad so that it was possible to find a stimulus example for most points that became a focal part of the frustrating impasses in the community meetings.

In addition to these dialogues other records were used, such as Gordon Jenkins' "Manhattan Towers," selected dreams from his "Seven Dreams," and the record of the sound track from the movie "The Little Fugitive."

Certain portions of sound association technique records which we had previously developed (Wilmer, Wilmer and Husni, and Briggs, Gaede and Wilmer) were also played, particularly the "angry father" sequence; but because of their less structured form and their extreme brevity, they were not so useful in a group where the turnover was so rapid as in ours. In groups formed for long periods of time, however, they might have considerable value.

brought into sharp focus an idea with which the group had been struggling tangentially for days, unable to handle it directly.

A general word of caution is necessary, however, about the use of records as stimulus material. One must resist the temptation to play a record merely to break a silence or to defer until tomorrow the arduous task of dealing with the painful thoughts and feelings that the group are reluctant to face today. Its value in the therapeutic process depends on this: To produce the desired effect, the record must lead to the heart of a problem immediately before the group, and its use must be in direct response to clues furnished by verbal communications from the patients. The decision to play a record, therefore, and the choice of record, must be made spontaneously in the meeting as the clue presents itself. The record must also be played early enough in the hour to allow adequate time for discussing the feelings and ideas evoked by it, and not so often as to lose its novelty effect, its impact, or divert the group from their primary functions.⁵

Sometimes the mere process of bringing the record player onto the ward in preparation to play a record would stimulate meaningful communications. In that case I found it wise to deal with these communications themselves and set the record aside. I found it advisable, also, not to keep the record player on the ward but to bring it in each time that a record was to be used. This made the playing of a record a special situation. It also removed the temptation to use the records indiscriminately at difficult moments in which they would serve no therapeutic purpose.

The situation in which a record should be used cannot, of course, be precisely defined since it depends on the circumstances of the moment. But the following instance will serve as a concrete

5. Looking back at my experience, I feel that on some occasions the record seemed to fit well the needs of the group and to help it considerably. But I am aware that on other occasions it may have given me personal pleasure that perhaps was not entirely derived from the solution of the group's problem. I am aware too that on a number of occasions I introduced the record because the tension in the group was so high and my understanding of the processes so vague that I could think of little else to do. It happens that I am interested in the use of records in group treatment. This is not to say, however, that their use is an essential part of the therapeutic community technique. It has to be considered that a group therapist does not always know what the group is doing, and certainly there were many occasions when frankly I did not know what to do for the best.

illustration of the use which we made of this type of material and the results that we observed.

In one meeting where the group had been discussing the "blame" of parents for a child's behavior, I played the record, "The Unwitting Influence of One upon Another." It is a story of a little boy who took to walking long journeys through the town, the father unwittingly stimulating his son's behavior for its vicarious pleasure. The story is perhaps a somewhat subtle one, and when the record ended, a schizophrenic patient immediately said, "What's that got to do with us, Doctor?" Another patient said, "It has a moral and it's a lesson. All the record tells is that a little boy didn't want to go to school, but it's got to do with blame, blame on the mother." A third patient said, "The mother disowns the child; when it's good she claims it, and when it's bad she says it belongs to the father." Then the patient who had asked the first question spoke up again, "You have to fill the empty places, when the father's not there." This patient, who was so frightened, so paranoid, and so confused that it was impossible for several days to get a coherent history from him, was an illegitimate child; so the missing father was of vital developmental importance in his life. While others saw the story as a lesson, a question of blame, and an example of the relationship of a father to his child, this patient saw it only in the light of the great empty void in his own life, where there had been no father. The following day he lay on his bed throughout the meeting, saying that he had a severe headache.

ATTITUDES TOWARD THE LEADER

The attitudes of the patients toward me reflected my dual role on the ward, that of psychiatrist and that of Naval officer. I was seldom addressed by my military title, however, or by name, but nearly always as "Doctor." My role as psychiatrist was sometimes referred to by the patients directly, and frequently indirectly; in one meeting it was established beyond a doubt by an episode which had dramatic effect. A very withdrawn schizophrenic, who was slumped in a chair behind other patients with his head in his hands, suddenly called out urgently, looking at the floor, "I want to see a psychiatrist." I answered quickly,

in a loud and almost angry tone, "Well, damn it, sit up and look at me." He did, and for the rest of the hour he seemed to be a member of the group.

In many instances the patients directed questions to me about my role: "Well, what are you trying to do, Doctor? Isn't it to get us to talk? Isn't that so?" I replied, "Yes." They often asked me questions, too, that were intended to explain their own attitudes and behavior, such as, "How would *you* feel if you were locked up?" But this I did not answer, first, because I didn't know and, second, because I would not be a "partisan," no matter how much I shared their feeling. It was not how I would feel but how they did feel that really mattered. But the comments most frequently addressed to me in my role of administrator were, "I want to go home. Get me out of here." Usually this was followed by a tacit nod to my role as a psychotherapist, "There's nothing wrong with me except physically."

Occasionally, when the patients felt hostile toward me, they got off onto the topic of "sick doctors," but the meetings seldom operated long as "gripe sessions." Occasionally a schizophrenic patient would so actively and ambivalently identify with me that he would act out a sort of caricature of the psychiatrist, answering all questions and alienating the group from him (and temporarily from me perhaps) at a very rapid rate.

A few patients asked me to speak *for them* in the meetings ("Ask him," etc.) and one patient, who was too depressed and tense to read the group a letter from his sister which he wanted them to hear, asked me to read it for him; at the end of an hour, I did. In the interviews a patient sometimes called me "Father," but this never occurred in the meetings.

Since I was not only the psychiatrist, but usually the ranking Naval officer on the ward, the attitudes of the patients toward me also reflected the variable attitudes in a military organization toward the commanding officer, usually quite positive feelings, *at least consciously*.

A veiled reference to my power and authority was sometimes made in the meetings. For example, on one occasion an officer-patient, in demanding that he be given a private room and a private head, said to me, "And you hold the big stick." The

illusion of my power also led to resentment toward me at times when very psychotic patients behaved aggressively. The other patients could not comprehend why, as the omnipotent leader, I did not authoritatively order psychotic disturbing behavior to subside or cease.

The situation was sometimes complicated by the fact that many enlisted men are extremely hostile toward officers. Not infrequently there were intemperate denunciations of officers and of the Navy. This hostility was often displaced quite openly onto the officer-patients on the ward, and some of it also inevitably spilled over onto me.

Situations of jealousy, rivalry, and identification with the leader (either me or the temporary leader in the patient group), which frequently developed, were also related primarily to my officer status, but more important, to my father surrogate role. One practical device used in dealing with this problem was the "doctor's list" by means of which interviews were requested. Since the patients who sought me out individually had to write their names on this openly posted list, the more dependent people were subjected by this means to the pressures of the peer group.

The one patient who was always seen in individual therapy daily was set aside to some degree as a "special case." This was noticeable in his behavior and communications in the meetings. But the other patients usually accepted this as evidence that, if they were sick and needed help, they would be treated similarly, rather than as evidence of special privilege or special devotion. Patients were treated "equally" only within the limitations that seemed reasonable and therapeutic, but "regulations" and ward rules applied equally to all.

The more disturbed schizophrenics, in particular, frequently manifested jealous rivalry for my attention by talking incessantly in the meetings, sitting next to me, and standing between me and any other patient who wanted to speak to me. Often, also, they would try to establish a one-to-one relationship with me by saying, when the group was silent, "Let's you and me talk," or "Talk to me," or "Let's go to your office and talk—no one wants to talk."

Rivalry with the leader was markedly evident in certain very psychotic officer-patients (also in high rated men) who felt depreciated and were struggling with a status problem. Outside the meetings, such a patient might try to cope with this problem by insisting that the other patients treat him with all the respect due his status, to the point where he completely antagonized and alienated them. In the meetings, his attitude toward me was intended to imply to the other patients, "We officers have certain things in common," and he also attempted in numerous ways to displace me as the person in control by his domination of the discussion.

One manic-depressive officer expressed his feelings of rank as follows, "I am *nobody* but a patient. I am not a Marine officer because I do not have my bars on." But his very communication established him as an officer, and was intended to do so. He also insisted on swabbing the deck on the ward, to the consternation of the Navy personnel, ostensibly as a gesture to show that he was "one of the men." But in reality he was saying, "If you don't treat me with the special consideration due my rank and status, I will behave like everyone else." (The ataractic drugs had no appreciable effect on this patient. His manic behavior continued unabated, and it was felt that the therapeutic community was not well suited for his care with the enlisted men.) Interestingly his behavior, contrary to ward custom, divided (consciously directed) the Marines, who, while disliking him as a person, came to his defense, and the Naval personnel.

The problem of jealousy also involved the question of discrimination. In one instance a patient who refused to work in the galley caused considerable annoyance and anger in the group. A sergeant, sitting on my left in the "deputy leader's chair," said, "If anybody gets out of galley duty it should be people with status, such as the sergeants or chiefs, but in here everybody leaves their rank outside." Since the man who had not worked in the galley was unnamed, I finally suggested that those who had refused to work should speak up. One patient did, saying that he had been on galley cleaning duty in the last ward and wanted a few days off before he did it here.

"And why is that?" I asked.

"Because of my back."

"But you didn't say that!" I pointed out; "you only said you wanted a few days off."

"All you have is social pressures," he pointedly replied.

"Don't you think there are such things as routines and schedules?" I asked. "We expect everyone to take his turn."

"Everybody should do it," another patient immediately added.

Finally the sergeant pronounced his judgment, "It has something to do with the unconscious and the sense of responsibility."

"It has more to do with the dirty galley deck than with the unconscious," I explained, and there was an obvious relief to have it placed on this common-sense level.

ATTITUDES TOWARD THE MEETINGS

In their first meeting on the ward, patients would often ask, "What are the meetings for?" or "What's going on here?" I rarely replied, for I felt that it was better to let them find out for themselves by experience with the meetings. On occasions, however, when a large number of new patients had been admitted the previous evening, I would explain the purpose of the meetings briefly at the start. But sometimes patients would volunteer an explanation. One such explanation, advanced by a psychotic depressed patient, was "The meetings are a means of helping, of friendliness, of getting along together, decreasing tensions." Then, acting upon his definition, he very appropriately began to tell of his own delusions, his dreams and fears.

Sometimes the patient volunteering an explanation would warn the new patient, "No one wants to talk about personal things in the open meetings," and would then launch into an extremely personal revelation of his own emotional problems.

In the middle of one meeting a very paranoid patient, who had been charging that the other patients were all mad at him, concluded by saying, "At least you can see one purpose in group therapy. It shows you who your enemies are." In another meeting where a schizophrenic patient had dominated the hour with incessant confused talk under great pressure, one of the patients gave him a little lecture, "The meeting is for everybody, and if the doctor wants to talk to you he will, and he'll do it in his

office if necessary. The meeting is for everybody, and nobody else can talk if you talk all the time."

On a number of occasions patients gave moving testimonials on how they had been helped and had helped each other in the meetings. In one such instance a patient said, "I've had a new chance, almost a new lease on life. Now I'm going to start all over again." Then he stood up and added, "What you really need is peace and quiet and to be able to sit down and think." Another patient suggested, "Maybe everybody needs more faith." A third patient agreed, adding, "Yes, faith in yourself, and then you can have patience."

And once a patient was overheard in the galley telling a new patient who was reluctant to come to the meeting, "Come on out there. There are a lot of intelligent people out there in the group."

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APPENDIXES

APPENDIX A

WARD REGULATIONS

1. Group meetings are held on this ward at 0845 to 0930 Monday through Saturday.
2. Visiting hours daily from 1400 to 1600. Wednesday, Saturday, and Sunday 1900 to 2030. No children visitors. Limit, two visitors at one time.
3. Shave call every morning. Do not miss shave call. This is not only important for morale but is expected behavior.
4. Shower call every afternoon.
5. No smoking in bunks. Smoking permitted, except during quiet hour, 1230 to 1330 or after 2200.
6. All letters are to be left unsealed at the nurses' station. This is a hospital regulation for the receiving ward.
7. Telephone calls may be made with the doctor's permission or the permission of Miss Greene.
8. The average stay of patients on this ward is 10 days. The only exception, as a general rule, is those patients who go to the open receiving ward, 49B. This decision will usually be reached within 24 to 48 hours. All other patients may expect to stay on the ward for the usual prescribed period of time.
9. Each patient will be seen by the Ward Medical Officer on admission. Any one wishing to see the doctor at any other time should write his name on the list posted on the board. He will be seen in order as time permits. If it cannot wait until you see the doctor, bring up the problem in the group meeting or at morning sick call, which will be held immediately preceding the group meeting Mondays through Saturdays.
10. Shopping for personal items such as cigarettes, toilet articles, soap, magazines, stamps, shaving cream, shampoo, sta-

tionery, candy, et cetera, will be handled through the nearest shopping list. The list is made out on Monday and Thursday. Shopping is done on Tuesday and Friday.

11. Special pay on Tuesday and Thursday only for emergency situations. Ordinarily your pay record will arrive here shortly after you do, and if your records are here you will be paid on regular pay days. However, you are limited in drawing only up to \$30.00 to be held in the Patients' Fund by the Administrative Assistant on this service. If you need to pay bills in excess of this sum you may have the money order obtained for you, if you have the money on the books.

12. Work details will be assigned and each patient is expected to take his turn in strict rotation system. Patients will be treated alike. Those patients who are too ill to perform their details need not be specially excused. Their illness will be obvious to all, and no one expects such sick patients to work.

13. Library cart comes on Thursday. Ask for special books you wish. The hospital maintains an excellent library and an excellent occupational therapy department. Patients are urged to participate in the occupational therapy activities of the hospital. You are permitted to go from this ward to occupational therapy, and those of you who are able are urged to visit the occupational therapy and find something of interest there.

14. On being transferred to other wards, change all linen on bed, clean out bedside locker, and wipe top and inside of locker. Patients going to open wards will change into uniform before leaving. Patients going to closed wards will keep on pajamas and slippers.

15. When addressing your mail you will use as your address: U. S. Naval Hospital, Oakland 14, California. Do not use Ward 55 as you may be transferred before you receive your answers.

Television will be turned off at 2200 every night unless the majority of patients request an extra half hour. Unless time is specifically granted by the Ward Medical Officer or the Officer of the Day, the television will not be on any evening beyond 2230. Reveille and Ward cleanup will be held regularly during the week, Monday through Saturday. Patients are allowed to sleep in Sundays and holidays. Shower call will be held at 1545

daily. A television and radio corpsman is assigned for the A.M. and P.M. Any change of stations or channels will be made only by the radio and television corpsman and not by patients. Please request changes through the corpsman, and changes must meet with the approval of the majority of the patients.

By cooperation and consideration of others the smooth running and friendly spirit of the receiving ward can be maintained. Any reasonable requests will be given due consideration. While some requests must necessarily be met with a negative reply, wherever possible reasonable requests will be granted.

APPENDIX B

SAMPLES OF NIGHT CREW NOTES TO DOCTOR

Note

To: Dr. Wilmer
From: Night Crew 1/7/56
Subj: Night Routine

(2400) Pt. Evans started the night by coming up wanting to wash his hands. States he was "all dirty from fighting the flood." Then pt. started out the door into the hallway, when stopped by corpsman. Pt. stated "Joe" was out there and needed help. Wanted something to pry the door open. Pt. was returned to bed (0030). Pt. is up trying all the doors on the ward. So far, does not seem to be upsetting as yet.

It seems to be hard getting anything thru to the pt. When corpsmen attempt to talk to him, pt. will sometimes butt in or just walk away. It appears that pt. is thinking far ahead of his actions. Of course this is only our conclusion. Would you tell us if we are on the right track?

(0045) Evans up again pacing around the ward, trying all the doors. At this time patient is talking to himself, corpsmen are unable to understand what he is saying.

(0115) Pt. is now down at the far end of the ward by the screen door. He thinks something is jammed in the door and is trying to open it. When pt. talks he has flights of ideas but they all end up in connection with the flood in some way or other.

(0200) Pt. was found in the rear of the ward by the door yelling "Hurry up Joe." He thought that was the elevator, he waited for it for a half an hour. Pt. then tried to get out into passageway again and with each attempt pt. became more and more belligerent. Pt. claimed there was someone out there waiting for him. (0245) Pt. now trying to open the windows, every

time the wind would blow the shade would move and make a noise and pt. would run over to it and start talking as if someone else was there.

(0300) Pt. shows very good signs of hallucinations. He was having a conversation about moving, pt. then moved all the chow tables, he symbolized pts.' lockers as statues. He had all the unused blankets on the floor. (0400) By now pt. has a lot of the other pts. awake, once now and then you could hear a pt. grumble but that was about all.

That pretty much takes care of the night. If there are any suggestions we would be glad to try them.

One other thing, Pt. Keller got up early (about 0400) and complained he couldn't sleep, so we asked him if he wanted to help us out sorting dirty linen and pt. wanted to so we put him to work. He enjoyed himself very much and corpsmen and pt. got to know each other a little more. Both Clement and I feel it was helpful but we would like your approval. Sometimes during the night pts. get up and want to talk things over and it quiets down a hyperactive pt. Would you let us know your feeling on this? Thank you.

Night Crew

Note

To: Dr. Wilmer
From: Night Crew 1/13/56
Subj: Night Routine

Relieved the P.M. crew, ward was quiet and secure. All patients in bed. Orders received from the P.M. crew on patient Jones going to hit patient Sullivan if he came by his bed once more.

0005

Pt. Smith:

Pt. came up to nurse's station asking to wash out his mouth. Pt. seemed very unsteady. Pt. leaned against wall and then against corpsman. Corpsman had to hold up the patient. Patient was escorted towards his bed, in which the pt. seemed to be able to walk by himself. Pt. then fell to deck. Pt. had enough sense to protect his head from hitting the deck. Pt. picked up and placed

in his bed. Corpsman was trying to get his pulse, which was very strong, when he asked again to wash out his mouth. Pt. was asked if he thought that he could stand up on his own. Pt. said that he would try. Pt. made it to the nurse's station very well. Pt. washed out his mouth with two med. cups of water, then started to drink the water. Pt. drank ten cups of water. Pt. was asked why and he replied that his tongue was burnt. Pt. went back to bed. Pt. kept repeating that he was going to die. Pt. said, "If I go to sleep I'll be dead." Pt. was reassured that he wouldn't die and to try to sleep, on which he did go to sleep.

0030

Pt. Fritz:

Pt. is lying on his bed awake. Pt. was friendly when conversing with staff. Pt. said that he had slept most of the day and wasn't tired. Pt. also said that he was just lying down thinking. Corpsman asked if there was anything that he could help him with. Pt. said that it wasn't that serious to talk about. Pt. didn't say what it was that he was thinking about, in which corpsmen thought that he shouldn't push the subject. Pt. laid awake and later fell asleep.

0045

Pt. Riley:

Pt. got out of bed and walked up to the rear of the ward by the screen door. Corpsman went up to him and suggested to him about going back to bed in which he was very cooperative and said all right. Pt. back in bed resting. In a matter of minutes he was asleep.

0100

Rounds:

On the making of rounds only two patients were slightly noisy. Pt. Thompson was snoring very loud, but didn't disturb the others. Pt. Smith was breathing very heavy in his sleep. His breathing sounded like a swift wind.

0200

Rounds:

No unusual moments of patients. Only that Pt. Ferris was sleeping on top of his blanket with his robe over him.

0300

Rounds:

No unusual moments of patients. Everyone sleeping.

0340

Pt. Tripp:

Pt. came up to the nurse's station with the bottoms of his p.j.'s wet. Pt. was given a clean pair of p.j.'s. Pt. said, "I'll wait until morning to change to the clean ones." Pt. got into bed and went to sleep with the wet ones on.

0400

Rounds:

No unusual moments of patients. All seemed to be asleep.

0410

Pt. Lee:

Pt. came up to the nurse's station and went to the head. Pt. came out of head and told staff that he didn't stay away too long and that he went over the hill. Pt. said this with a sly smile on his face as if he had done something big. He sort of said this in a way of bragging. Pt. went back to bed and sleep.

0450

Pt. Roller:

Pt. came up to the nurse's station and asked if he could use the head. Pt. went to the head and went directly back to his bed. Pt. shows no change in the expression on his face, but did not stall around like he usually does.

0500

Rounds:

No unusual moments of patients. All seemed to be sleeping.

0530

Pt. Riley:

Pt. got up and went to the head. Pt. started to walk around the ward. Pt. is suggested to go to bed. Pt. said that he would go to bed a little later, in which when a little later comes around he forgets where his bed is. Then he repeats himself again, that he'll go to bed a little later. Pt. would talk about things that are not even on the ward, or even a thought that the table would be a car, etc: pt. asked staff about selling his truck then

would jump to another subject as flowers on his wife's hat. Pt. most of the time thinks of going somewhere.

0600

Lights on, coffee on the ward, clean linen passed out, patients awaking. Concludes the routine of the night.

Note

To: Night Crew 55
From: Dr. Wilmer
Subj: Ward

(Summary of group meeting) Things seem to be fine. I was pleased at how the ward ran while I was away and that you felt it was satisfactory. Beachum has calmed down quite well tho he is still on the edge. We have discontinued his serpasil, which he thought was poison, and I have been seeing him daily for brief interviews. He says, "I don't want any trouble," and he's had enough in his life. He is getting well. Had we switched to chlorpromazine we would have decided it was a "miracle." Lt. Anderson is somewhat argumentative and is quite sensitive about pride. It will pay dividends if you speak to him as "Lieutenant." I think he will do OK here but feels he is not sick. Also Caputy is quite delusional and withdrawn but I think he will pull out of it quickly too. He was in the brig at TI for assault. I don't know exactly about the recent episode but he is quite acutely psychotic. Smith is suspicious of others but friendly when approached.

I'll be on 56 tonight . . . call me if you have any questions.

H. A. Wilmer

Note

To: Dr. Wilmer
From: Night Crew 1/26/56
Subj: Routine of Night

The night was very quiet. The only complaints of noise was of two patients. (1) Pt. Cohen was coughing very hard at beginning of nite. Pt. had some water but didn't seem to do too good. Pt. finally stopped coughing and went to sleep. (2) Pt. Smith

came up to head a few times. Pt. said, "I feel like having a B.M. but when I get into head I can't do a thing. At reveille the only patients that are up are pts. Kamp who said that he slept real good and Pt. Beachum who did not make hardly any noise, made up his bed and sat in a chair listening to music. Pt. went back to bed but is not sleeping.

Night Crew

Note

To: Dr. Wilmer
From: Night Crew 1/30/56

We had an extremely difficult night last night with all these new admissions the ward was tense when we came on duty. We had a very hard time trying to quiet down the ward after the T.V. was secured. Pt. Caputy made a desperate try to get off of the ward. He got halfway down the passageway until corpsmen were able to catch him. Pt. was brought back onto ward. The NPOOD was present at the time and talked to pt. Pt. did quiet down a lot.

The one pt. we had a lot of trouble from was Lt. Anderson. He has caused a lot of trouble on the ward. Pt. uses his rank over the enlisted man and tries to get them to do different things such as throw pillows at the nurse's station or try to get through the passageway, and even pick fights with the corpsmen.

Pt. is always trying to get the corpsmen to hit him. Pt. called us queers, pimps, dirty rotten bastard, etc. He referred corpsmen to bananas, first green then yellow and finally rotten. Pt. would get two or three of the sickest pts. in a group and tell them not to do anything we asked because we were out to hurt them.

Dr. Wilmer this is a very difficult problem. In about a two hour's time this pt. can have half of the ward so upset it is almost impossible to get them calmed back down to normal. Pt. Anderson does it in this way, "You go ahead, fellows, I'll follow." Then when he sees things aren't going the way he planned he steps out of the picture and rest of the pts. get the blame.

He started taking notes on the corpsmen so I suppose you will hear some drastic things. We would like to know how the ward meeting will go this morning. I feel it will be all together differ-

ent than they have been. We have a completely different kind of ward now. I find the age group is much younger and the reaction to the disturbances at night are a lot different. Last night we had a completely different reaction. They did not respond as a group, but seemed to be scared, and they seemed to shy away from the situation.

Pt. Rush is very attached to Pt. Anderson. Pt. Anderson has him completely in his power. Last night Pt. Rush did most of the advancing as far as causing trouble. Every time we would stop pt. from doing something Pt. Anderson would yell out, "If you touch that man I'll break every bone in your slimy body."

Both Pt. Anderson and Rush took their blankets and laid down on the floor together, then Pt. Anderson put Rush in his bed and stood watch on him the rest of the night.

If you have anything to offer in the control of the ward or what we could do as far as Pt. Anderson goes we would appreciate any suggestions.

Night Crew

Note

Dr. Wilmer:

1-31-56

Last night was a little more calm and quiet, the only pt. we had any trouble with was Rush. He came up to the nurse's station and had two sharp pencils. He came when Corpsman Gannon was in the nurse's station alone, Corpsman Clement was back sorting dirty linen.

Pt. Rush was very demanding and said I was to die. I pretended I didn't hear the pt. at first but pt. made a few lunges that came a little too close so I attempted to relieve pt. of the pencils, at the same time pt. picked up a flashlight and hit Gannon on the head. Gannon had to grab pt. because he still had the pencils. Pt. was then taken to bed, the rest of the night was quiet. Rush got up a couple of times, came half way down the ward and returned to bed.

In all the noise and commotion the rest of the pts. didn't react whatsoever. This will probably be brought up in the group. We would like to keep informed as close as possible on these pts.

Night Crew

APPENDIX C

CONSULTANTS' EVALUATIONS OF THE PROGRAM

ANALYSIS OF GROUP THERAPY IN AN ADMISSION WARD, UNITED STATES NAVAL HOSPITAL, OAKLAND, CALIFORNIA

*By GREGORY BATESON**

The purpose of this report is to analyze some of the processes which operated upon this ward which I observed for one week, and to give such an account of these processes as may be valuable in case it should be decided to repeat this experiment.

It is not the purpose of this report to evaluate the results achieved. To do so would require continued contact with the ward and a sort of data which the writer does not possess. On this aspect of the matter, all that can be said is that I personally was very much impressed with the probable therapeutic value of what was happening and have no doubt that the record of the ward over time would amply substantiate this impression.

The various circumstances which contributed to the effectiveness of this very extraordinary therapeutic community will be enumerated in order of the ease with which they might be reproduced. This list will range from the circumstance that the ward was part of a Navy hospital to such intangible circumstances as the personalities of Dr. Wilmer and his staff, without which no identical community could be set up. No individual is indispensable, and I shall consider, when dealing with these intangible factors, what steps might conceivably be necessary to permit the growth of a therapeutic community around personalities other than those which determined the course of this particular experiment.

* Visiting Professor, Department of Sociology and Anthropology, Stanford University. Ethnologist, Veterans Administration Hospital, Palo Alto, California.

I. The Ward as Part of the Navy

The writer's experience of mental hospitals other than this has been limited to civilian hospitals and it is necessary to stress the very fundamental contrast between a hospital which is part of the Navy and these others. Perhaps the most serious single drawback of a civilian hospital is the fact that it consists of an organization which calls itself "the staff" and a number of persons not organized and not a part of this organization. These persons are called "the patients." The members of the staff see themselves as an organization whose purpose is to work upon the patients. The analogy of a factory comes to mind: raw material enters in the form of sick individuals and ideally this material is processed into a product—dischargeable individuals.

Now, the very essence of the theory of the "therapeutic community" is the premise that the patients be members of this community. To establish the premise—to make it a part of the unconscious habits of both the staff and the patients—in a civilian setting is exceedingly difficult; but to do so in a naval setting is very much easier. The lines are differently drawn. The category of Navy belongingness includes both staff and patients, whereas in a civilian hospital, there is only the line between what one patient called the "insane and the outsane," and this line divides the patients from the staff.

Moreover, the Navy is organized to enable men to cooperate in combat, and while the struggle against mental illness is, of course, very different from combat against an external enemy, this more subtle struggle is never quite absent, even on the battleship.

To set up a therapeutic community within a naval setting, it is first of all necessary to permit and foster this psychotherapeutic phenomenon between men, which is already a part of naval tradition. Fundamentally, this, I believe, is the most important thing that Dr. Wilmer was doing.

From a conventional psychiatric point of view, the history of the ward would appear miraculous. "Quiet rooms" and restraints were unnecessary in dealing with the random sample of patients which passed through the admission service over a period of 10 months. My own first impression was that this phenomenon

could only be accounted for in terms of Dr. Wilmer's "faith" in human beings. I think, however, that it is not necessary to be mystical about this matter. What he had faith in was, in effect, a rather simple and rather familiar phenomenon: the motivation of men to create a group in which membership is not too frightening and not too uncomfortable. This phenomenon had been at work less intensively in the naval settings from which the patients came. It was an unwritten tradition of the Navy setting, and what was necessary was to permit and foster this phenomenon.

To the psychiatrist, it might still be surprising that these men, themselves mentally sick, showed such good unconscious judgment in their decisions of when to be impatient and when to be sympathetic. After all, the psychiatrist himself had had many years of professional training to achieve this skill and might well lack the faith necessary to believe others capable of it. I think, however, that this problem is partly solved when we remember that the daily group therapy is a means by which the psychiatrist is providing a model for the sort of help which the patients will give each other during the rest of the day.

II. Rank and Familiarity

A civilian entering a naval installation is immediately conscious that every move is organized in terms of the naval hierarchy. The movements of patients among themselves—who associates with whom, who sits where in a group therapy session, and so on—all of this is related to rank, and the same is, of course, true among the staff. What needs to be said about this particular ward is that while the naval system of respect was never for a moment absent, and while there was never a relaxation of the respect, there was also an unexpected undercurrent, a theme of common humanity and shared goals which ran in counterpoint, woven in with the hierarchic forms. Let me first illustrate this contrapuntal theme of humanity or familiarity. One of the striking incidents I observed was as follows:

Dr. Wilmer was absent and a corpsman brought me my lunch in the doctor's office, where I was sitting in front of the desk working up my notes. I had avoided sitting in the doctor's chair, fearing that to do so would be invasive. While I was eating, the corpsman came back and sat in the doctor's chair. A conversa-

tion started. He started to gripe, and I got the idea from his conduct and from his gripes that I was getting a sidelight upon the organization of the ward which only an outsider would be permitted to get. While the gripes were in full flood, Dr. Wilmer entered. The flow of complaint went on unchecked. Dr. Wilmer, standing beside the desk, entered the conversation as though this were the most natural thing in the world (which it evidently was). After several minutes, the corpsman was called away and the doctor sat down in his own chair. When he had done whatever he had to do, the corpsman returned and the conversation continued. It is perhaps true that only a civilian visitor would have been permitted to see this, but what is important is that what I was permitted to see and hear was not something which would be concealed from the commander of this therapeutic community.

A few minutes later, a nurse entered and sat down. She said she was a little worried; the doctor asked what was the matter and she said that she was expecting a letter from her mother; whenever she looked in the mailbox she sort of expected that letter. Did Dr. Wilmer think she should be worried about this? The doctor talked a little about mourning, and when I realized that the nurse had come in to get psychiatric help from the doctor in my presence, I turned off the tape machine and we talked briefly about grief. After a little while, her immediate need was apparently satisfied and she turned the conversation to the daily affairs of the ward, and I again turned on the tape recorder.

And then there is a case which I did not witness but only heard of by report. A violent patient was brought in and used a chair as a weapon, and the doctor felt that in this particular case, it would be unfair to his staff to insist that the patient be handled without electric shock. He said that after all, somebody might be hurt or driven to an improper use of violence in reply. His staff might suffer or the success of the whole experiment might be endangered. He therefore ordered shock, but one of the corpsmen faced him and said, approximately, "Doctor, I've gone along with everything you've done so far, but I don't go for this."

Significantly, however, Dr. Wilmer rarely or never wore his

uniform coat on the ward but wore a white coat. He performed the functions of a doctor while wearing collar insignia of rank. What seems to be important is that the system of naval respect is continually used to give emphasis and value to the human goals of the whole system. It is not that the doctor loses prestige when the corpsman says, "I don't go along with you in this"; rather, the ultimate human purposes of the whole system are underlined when that which everybody recognizes as important—the forms of naval respect—is waived in favor of these purposes.

Further, this combination of human familiarity with status respect is perhaps a necessary ingredient of all therapeutic change. Cathetic change is, essentially, the discovery that every coin has two sides. In a Hegelian sense, the patient must be faced with thesis and antithesis, and from this dialectic must achieve his own synthesis. The psychotic and the neurotic and all whose mental disorder stems from the early relationships of childhood have an unsolved problem regarding authority, so that to resolve the problem of psychotic rebellion in a ward situation, it is theoretically indicated that the patient should face thesis and antithesis regarding the nature of authority. I believe that this dialectic actually was created on this ward by the juxtaposition of authority and humanity.

It is not merely that the "soft word turneth away wrath." Any attempt to repeat this experiment might have to be careful in this regard; to "humor" a violent patient may sometimes be expedient but is not, in the long run, therapeutic if in humoring the patient the therapist is actually falsifying the real relationships which exist. I saw no moment on the ward when the doctor or any of his staff pretended, for reasons of expediency, to have a patience or kindness they did not feel. At all times they were conscious of status and permitted their simpler and more human reactions to coexist with the consciousness of status. What was implicitly communicated was: there is no conflict between these elements; the doctor is not afraid of a conflict between his feelings and his status; he is, therefore, not afraid that any expression of feelings by a patient might reduce his prestige as a doctor; the patient need not be afraid.

III. The Group Sessions

Every morning, immediately following rounds, the doctor sat in a chair about halfway down the length of the ward and a group therapy session began, lasting from nine o'clock until about ten. The patients sat either on chairs or on their racks, and a considerable part of the doctor's staff were usually present. One of the corpsmen, commenting on his own absence from one of these sessions, said, "I almost brought myself to come to that meeting this morning."

To understand what these sessions mean, it is necessary to place them in time. First there is the brief naval ceremony of rounds, involving a momentary face-to-face contact between every patient and his doctor, who would use this contact for the brief greeting by name of any new patient who might have come in during the night, and an occasional word of inquiry to others; it is from this context in which the patients stand to meet their officer that they move to their informal positions to talk among themselves and with the doctor. And, interestingly enough, the entry of other members of the staff onto the ward coincides with the shift from naval ritual to therapeutic exchange.

Following the session, the doctor and his staff withdraw. The patients are now on their own. The group breaks up but the conversations started in the group continue; the tempo of the group session has set a style or themes for the day. The staff, on the other hand, now meet in the doctor's office immediately after the group session and review what occurred. They are made to look at the larger group in which they themselves were members a few minutes previously. These discussions commonly started with a map drawn by Dr. Wilmer on the blackboard. This map showed the positions in which the patients and staff members had spontaneously chosen to sit during the meeting. The members of the staff thus literally saw themselves as a part of that community. But in this new context they are looking at themselves, and the discussion naturally investigates not merely the behavior of this patient or that patient but the behavior of patients and staff members in relationship.

There was even a certain friendly emulation or competition to recall and interpret what had happened in the group session.

It is difficult to remember the complex themes and weaving of interaction in an hour's session involving twenty or thirty people, and the attempt to do this, becoming competitive, became also a training in observation and a sort of psychotherapy, with both individual and group goals. The goal for each individual was the discovery that simplicity of personal expression and awareness is safe. The group goal was the emphasizing of the premise that the therapeutic community includes both staff members and patients—even that it includes the doctor himself, whose reactions and words are subject to the same scrutiny as those of the patients.

The fact that for a period these sessions were completely recorded on film indicates that Dr. Wilmer was by no means averse to tension of this sort. Indeed, it is my belief that the tension is an essential ingredient of the therapeutic processes involved.

Dr. Wilmer sat comfortably and waited. I am told that once a whole hour passed in silence, but this was exceptional. More usually, after a while, somebody would speak and the speech might be anything ranging from administrative questions about pensions or ward rules through intangible statements about personal matters to extremely psychotic and confused utterances. Dr. Wilmer was in no hurry to answer and would even continue his own silence after this first breaking of the ice. What was communicated by such continuing silence on the part of the doctor was essentially affirmative, an implicit "yes" which opened the way for a great variety of possible developments. On one occasion, I felt that Dr. Wilmer's silence was a brush-off and this was in response to an extremely psychotic utterance which was unintelligible to me.

In general, both Dr. Wilmer and the group were extraordinarily patient even with very confused speech, when there was any indication that the speaker was groping towards saying something important to himself. Whenever this was so, they would let him take up long sections of time and would even join him in his groping. But both the doctor and the group were rather sharply impatient of *crystallized* delusional material. For the most part, this sample of patients contained few whose delusions were established to the point of becoming idiosyncratic

cliches in the patients' utterance. For this sort of thing there was no tolerance.

It might be fair to say that the behavior of the group and of the doctor followed a rule somewhat like this: if possible we will treat whatever any man says as a groping towards understanding, but if he labels his speech so definitely as certain dogma that even we cannot respond *as if* he were attempting to investigate and clear up his confusions, then we can only be impatient and show our impatience either by a negative silence or by the snub of a change in subject or perhaps by restlessness. Even in extreme cases by telling him to shut up. Extremely psychotic behavior and talk were ruled out not as being nonsense but rather as too dogmatic for profitable reply. The group exerted its repressive measures by insisting implicitly that whatever was said be open to reply—a sort of democratic tyranny which perhaps did much to discourage and disqualify psychotic behavior.

The following excerpts from the tape recording of a staff meeting will serve to illustrate some of the principles which seem to be at work. A fight had occurred on the ward that morning between two patients, whom I shall call Schmidt and Norton. The group was unusual in that it included a visiting doctor and members of the Pacific Combat Camera Group who were later to film the ward for a month.

Excerpt 1: Dr. Wilmer: "Schmidt sat next to me, partly for protection, partly defiance, partly taking the leader's chair. He was the therapist—'You don't need psychiatrists—you don't need doctors.' Then he started to be a little rough, pulling the guy out of bed. I finally said, 'Don't do that.' He was yanking his arm. Despite this, he stopped being rough and got him out of bed, sat him down, saying, 'There's nothing to be afraid of. I'm here.' He is the protector. He is acting something relating to the fight earlier, for the group to see. This is the guy who says he is not afraid."

The episode and Dr. Wilmer's comment can only be analyzed through the latter, but it is important to emphasize that we are here looking both at the staff meeting and at the group meeting about which they are talking as events in a total com-

munity. Dr. Wilmer places Schmidt's behavior in an interpretive frame: "he is acting something"; "he was the therapist"; "partly protection"; "partly defiance". Dr. Wilmer narrates his own intervention: "I finally said, 'Don't do that,'" and narrates that *despite this*, the patient obeyed his command.

This is a very complex sequence. Norton is absent while his hand is being treated; and Schmidt's response is this complex behavior, partly defiant and partly exhibitionistic of the role of protector. From the group's point of view, this response is idiosyncratic and unintelligible. Later in the group meeting, Dr. Jurgen Ruesch, who was present as a visitor, points out that Schmidt is of German origin and that his behavior would be intelligible to a German group. But here it is not intelligible and, in fact, falls into the category mentioned above of crystallized idiosyncracy. It is not a groping; it is something to which it would be useless to reply.

Excerpt 2: Dr. Wilmer: "The psychopath, he turned to Schmidt and said, 'You didn't hit him right,' something about holding your hand right. It was a relief to the group. They sort of laughed. This was quite a relief."

This is an interesting pay-off in which the actual pathology of a patient who is referred to as a psychopath provides a frame within which, momentarily, the group can see the fight in a way that alleviates their anxiety. But notably, it is a frame which does not fit at all with Schmidt's theatricals. It is a frame which makes his defiance of the group and of the doctor utterly irrelevant and causes his role of "protector" to look almost hypocritical.

Excerpt 3: Mr. Briggs: "There were some interesting smiles on the patients' faces when you said, 'The Navy wants to take pictures.'"

Chief Kuhn (director of camera crew): "This boy, Jones, who sat next to me, said, 'You want movies of this?' That was when Schmidt was making his little speech."

The group is under tension of two sorts: there is the tension from the fight and the tension caused by the presence of the movie team. With unconscious ingenuity Jones uses one tension-making factor to frame the other. He responds accurately to Schmidt's theatricals and puts them in the movie.

Excerpt 4: Mr. Briggs: "When I was going out, that Chief caught hold of me and sort of couldn't let me go. He said, 'You know, the reason why the group was so quiet today is that I think the patients felt guilty about this fight. It could have been prevented.' They have been trying to make excuses. It is as if they were saying, 'Well, he has been pestering us and pestering us.' He (the Chief) said, 'I'm able to control myself, but he has been asking for it.'"

What the Chief really said to Mr. Briggs we cannot, of course, know. What is interesting is the way Briggs describes it, attributing to the Chief a role which would have been appropriate to a member of the staff, diagnosing and commenting on the group session. In the way Mr. Briggs talks, he and the Chief are almost one and the same person. He, too, feels something of that guilt. He even makes the Chief say that his *thinking* this has caused the group to be quiet.

Excerpt 5: Mr. Briggs (continuing): "This all got started this morning after the patients on the ward could have prevented it. But they sort of egged it on, and he (the Chief) said, even himself, 'I didn't do it because I figured that Schmidt is pretty sick and I don't know what you are dealing with. If I went up there and pulled him away and there were two sick minds, you never know what is going to happen. I want to keep my record clean. I didn't want to get implicated in a fight. I know they write incident reports on these things and I didn't want my name on it.' But he said he felt bad about it now. He could have helped him."

Again Mr. Briggs confuses the pronouns, identifying with the Chief. The incident also takes on a new dimension. The Chief is now doubly a member of the therapeutic community. In Mr. Briggs' first speech, we saw him as the diagnostician; now he is a patient who has failed and risen from that failure by describing it to Mr. Briggs. This places him both as patient and as would-be therapist.

Excerpt 6: Dr. Wilmer: "They are just not used to seeing fights on the ward. There is nobody provoking it. This is the least provoking time of any since Schmidt has been there. We have

had a lieutenant here, a very provoking situation. He (the lieutenant) was constantly antagonizing Schmidt. Well, they certainly did not come to his rescue. They weren't the least bit interested in Schmidt. They sort of welcomed him talking and being left on the limb, and when I invited him to talk and said, 'Can anyone help him?' nobody said a word."

Mr. Briggs: "They helped the other patient."

Here again we have the picture of Schmidt punished for his (probably foreign) idiosyncrasies.

Excerpt 7: Chief Kuhn: "Together with the aftermath of the confusion on the ward, of the fight, and then with so many strangers as visitors in there this morning, I think my observation was, that was the probable cause of their being so quiet, which it was the other day when we were up here. I remember when we walked in the ward they all turned around, looked at me and everything got really quiet. It's amazing how quick they are to observe."

Here, correctly or incorrectly, the speaker veers towards feeling that the quietness on the ward was a comment on his own presence. He mentions the fight but drops it and focuses upon the self-referent angle as he continues. He is only newly—or perhaps not yet—a member. Dr. Wilmer accepts this view of the matter and takes the pressure off Chief Kuhn in the next excerpt.

Excerpt 8: Dr. Wilmer: "I wonder if this is not it: 'We are not going to air our family fight for strangers.' The fight has occurred, a whole bunch of people come in—photographers, professors, observers, and these people were not going to talk about their family fights. If one of their sicker boys pops one of their other very sick boys, well, just talk to the doctor about it, and even Schmidt himself said, 'Well, we don't need a doctor.'"

What he has done is, first of all, to point out that Chief Kuhn is not the unique visitor, and finally, to include himself in the self-referent picture, thus implicitly pulling Kuhn into membership in the community. He continues: "I had to bring the fight up. I took a more active role in this group than I usually do." The deviation from the usual was not only the presence of visitors but was also in the behavior of Dr. Wilmer.

Excerpt 9: Dr. Wilmer (speaking about a previous meeting): "In a sense, this was a very anxious group. They were not able to talk about what they wanted to and their silence was, in effect, therapeutic—being able to sit there, to look at Schmidt and Schmidt to look at them was good. He defied me by saying he was not going to sit down. It was a free country. I said, 'Well, we are inviting you to sit down.' He said nothing more for a few minutes and then said, 'I will sit down,' which he did. I think I felt there was no point in trying to make him sit down. He made himself sit down in response to this. This was good."

The authority of the doctor here does not take the form of giving a command but of defining how his message is to be classified. It is not a command; it is an invitation. The only command is that the message be taken as an invitation; and this command, I am sure, was issued with great authority. This process—the defining of the sort of message a message is—is one of the essential gambits of the psychotherapeutic process. The therapist assumes that in childhood the patient has been tricked and deceived a thousand times by parents and other authority figures who have lied about the classification of their messages: "Wouldn't it be nice to put on our shoes?" is really an authoritarian command, and "Don't bother me!" is really a seductive invitation to further whining. But in childhood, there is an implicit prohibition which prevents the child from openly identifying these messages for what they are. Most children act correctly upon what the message is, but neither the parent nor the child may recognize this fact. Psychotherapy is the overt and explicit identification and correction of these distortions. With this correction comes an identification of self: "*I will sit down.*"

Excerpt 10: Dr. Wilmer (still speaking about a previous meeting): "When the lieutenant was attacking me verbally, this created some anger in me, but rather than tell him off or rather than point out what he was doing, I kept silent. I think that the control of the leader, to be silent, to have the silence—this is what was going on."

What is striking here is Dr. Wilmer's assumption that his anger is known to the group and that therefore his silence becomes a statement to them of how he is controlling his anger. It

is not that the silence is a concealment of anger. The control of the leader is to be communicated to the group—both that which is controlled and the fact of the control. This is not the poker face of the psychiatrist in a caricature. This is the leader who assumes that he is totally visible to the group and that his choices of how to act can therefore be a model for their choices. And again, this is aimed at permitting an identification of self. If he presents his silence as his choice, defining it as a certain sort of message, it becomes possible for the others to *have* their silence.

Excerpt 11: Chief Kuhn: "I can see where it's going to take a couple of days to get used to them before trying to do anything—so they will know us, and if we make a move they won't become tense and silence prevail, because what we want them to do is talk naturally."

Dr. Wilmer (turning to Dr. Ruesch): "You had some ideas about Schmidt—an interesting cultural phenomenon."

Kuhn's speech may be all right as a statement of the course of action which he proposes, but it is curiously and complexly out of kilter with the whole philosophy of the group in which he is becoming a member. He gets a brush-off from Dr. Wilmer, who changes the subject. To correct somebody who is right for the wrong reasons is incredibly difficult. For one person to try to influence another to behave "naturally" is paradoxical. It is not possible to obey the order "Be yourself" because if this is an order, that which is done in obedience to it is only obedience. Kuhn avoids this rather extreme error but substitutes for it the notion that if he and the movie team go quietly for a couple of days, they will be able to stalk the group into talking naturally. But stalking or seduction is no more a way of creating naturalness than is command—and for the same reasons. What Kuhn has not discovered is that he is a member of the group—and he has not discovered this because it is not yet true as a spontaneous premise of his thinking. From where he sits he can only see himself and his team as operating upon the group. This is precisely the point that was made earlier in this study when I mentioned the situation in a civilian hospital in which the staff see themselves as operating upon the patients. But for Dr. Wilmer to have told Kuhn about this would not have been effective.

Kuhn has to make a step which will be an involuntary change within himself. He has to grow into group membership, and it would be equally contrary to the philosophy of the whole therapy for Dr. Wilmer to command this growth. All he can do, under the circumstances, is to change the subject, and thereby to say implicitly and gently, "That is not it; that is not it at all."

Excerpt 12: Dr. Wilmer (to Dr. Ruesch): "If you didn't know these people were in the service, would you have had any feeling that this was a definite cultural group, something different about this group as a group of young men?"

Dr. Ruesch: "Yes. I think that in another group you would find more incentive towards self-action. There is something waiting about this. It may be today's meeting. I have no way of telling, but there was something. There is plenty of time. They can wait a day, a week, a month. It really makes no difference. But this is not true in an ordinary group. You have the pressure, where time is money, of 'got to get things going, got to look out for myself. Let's settle this thing. Let's get going.'"

Dr. Wilmer: "That is my interpretation precisely in the group. I had not thought of it that way when I said, 'We won't come to any clear summary of this group. We will meet tomorrow.' It had not occurred to me, but it must have been the same feeling I got—we're going to meet tomorrow.'"

Here again we encounter a curious and fortuitous resemblance between the Navy and psychotherapy. The resemblance lies in the fact that for a large proportion of Navy personnel, their time within the framework of the Navy is separate and suspended away from their ongoing civilian careers, which will later be resumed—with a difference. This is also the situation of the patient in analysis or of the group of passengers on a liner. It is, therefore, doubly true of the mental patient in a naval hospital. He is within that frame which is the Navy, and within that frame which is withdrawal from pragmatic life into concentration upon psychic growth.

These frames have their use in creating certain sorts of freedom. The passenger on a liner or the patient in an analytic consulting room experience in different ways different sorts of special freedom, and we may summarize the whole of the experi-

ment on this ward as an attempt to use this freedom. Conventionally, a ward is a place of confinement. The door is locked and, euphemistically, the patient is said to be in a "controlled environment." Upon the ward which we are discussing, the door was no less locked, but what was used for the growth of the patient was the freedom which this shutting out of the pragmatic external world permitted.

IV. Conditions for Repeating the Experiment

From what has already been said it is evident that the main ingredients of the situation on this admission ward were simply the circumstances of any such ward within a naval setting. The problem of repeating the experiment is merely one of using these circumstances in a positive rather than a negative way. To do this, however, involves a particular philosophy in the person who has command of the situation. Moreover, this philosophy is more than a mere recipe. Just as it would not have been effective for Dr. Wilmer to tell Chief Kuhn how his thinking was out of kilter with the situation in which he found himself, so it would not be effective to tell any ward commander chosen at random to run a ward on these lines.

But notably, the staff was selected largely at random and by experience of the situation gradually discovered that it would work. They did not at first believe it and they did not at first know what order of command this was that the doctor was emitting. For one member of the staff, the shift seems to have occurred dramatically one night. Dr. Wilmer had left orders that the nurse could call him if she thought there was anything he could do for a particular disordered patient. The patient was difficult and was disturbing others, and the nurse called the OD, who took minimal action—a course which the nurse fully understood. Finally, however, feeling that she was acting almost a caricature role, she called Dr. Wilmer at his home at about midnight. Dr. Wilmer replied casually that he would be there in about an hour, and drove the forty miles to the hospital, arriving to find the patient quietly asleep. The nurse was prepared to take a certain malicious satisfaction in this anticlimax, but was shaken by the doctor's reaction. He was just mildly pleased. She recounted the story to the OD, from whom I heard it.

The point is that the experiment could not be set up merely by defining for the commanding officer that he must drive forty miles in the middle of the night whenever a patient needs him or whenever a nurse is anxious. What cannot be defined by orders is the casual response to the anticlimax which convinced the nurse of Dr. Wilmer's integrity. Integrity cannot be gotten by command, but, strangely, it can be transmitted. "The truth cannot be told so as to be understood and not be believed."

Essentially, the problem for any repetition of this experiment would be a problem in personnel selection—to choose as commander of the experiment somebody for whom the forms of Navy respect have both pragmatic and esthetic value but for whom these forms are not necessary to alleviate anxiety.

All this does not mean that the experiment could only be repeated with "another Dr. Wilmer." Somebody entirely different might play the catalytic role. The minimum requirement is affective integrity and a belief that this integrity will permit the identification of self in others. Lacking these characteristics, it is doubtful whether any psychiatrist can help the psychotic. With them, probably any individual automatically helps.

The psychiatrists who have success in this field range in character from extremely extroverted persons with great zest and authority to others as gently humorous as Fromm-Reichmann. There are successful male psychiatrists who feel a pain in their own breasts when they give food to a psychotic patient, and others who in the same situation simply feel an expansive manliness. But both may be successful. There is no rule as to what the psychiatrist ought to feel. The only rule is that of integrity. It seems that the schizophrenogenic are those whose feelings can only be expressed through a thousand distorting mirrors of "oughts"; and that the patient's hopeless confusion regarding the nature of every message which he receives or emits is a result of dealing with people of this kind—especially in infancy. It must, therefore, be helpful to deal with somebody whose messages are not complicated in this way, who when he is being theatrical is honestly theatrical and who when he is simple is recognizably so.

The problem of constructing another such therapeutic community hinges upon finding leaders with these very general and not too rare characteristics.

**MEMORANDUM ON THE OAKLAND
THERAPEUTIC COMMUNITY***By WILLIAM G. BARRETT, M.D.**

This memorandum concerns two visits as a consultant to the admission ward at the U. S. Naval Hospital, Oakland, California, so aptly described as a 'therapeutic community.' The aim of establishing this type of organization is to eliminate the authoritative, directive approach in the handling of a group of patients and to substitute for it a group morale and a mutual understanding in the patients which will favor controls from within rather than controls from without. Experience in this approach, both in England and on this ward, has demonstrated that with proper guidance and understanding, this aim can be achieved in large degree. This leads to a much more individualized form of treatment, to the absence of necessity for restraints, and to the minimal use of sedation.

It has also been demonstrated that the therapeutic effects, so far as the individual patients are concerned, are greatly increased, and quite frequently even the most bizarre and extreme symptoms are relieved, at least temporarily—that is, during the period during which the patients continue in this therapeutic community. A group morale develops which is characterized by an astonishing degree of mutual understanding among the patients for one another's difficulties and problems, and it would often seem that the ministrations of patients who are not so sick are better accepted by the very sick patients than the ministrations of the trained staff. This reminds one of the situation that so often exists in a family, wherein recalcitrant children continue to disobey the parents but are immediately amenable to the words and directions of brothers and sisters of nearly their own age.

My consultation on the second visit in February brought out features quite different from my visit of September. On the earlier occasion, I was able to observe the beneficent functioning of the group. During that meeting, a number of the patients participated, and with the help of data obtained in the staff meeting following the group meeting, it was quite possible to

* President of the American Psychoanalytic Association.

understand that I had observed in action various therapeutic forces of significant importance. The second meeting, on the other hand, demonstrated one of the limitations of this form of treatment, for it showed very clearly how one hostile, aggressive individual, highly competitive with all authority, litigious and argumentative, can sabotage a therapeutic community meeting. But it was interesting to observe how this man, a manic-depressive officer, operated by allying to himself a very sick, delusional schizophrenic patient, to form a twosome group within the larger group which prevented the other patients from participating in a true group session. Nevertheless, in spite of this attempt to take over the group, there were several critical remarks from the other patients, and during individual talks with several patients following the group meeting, I discovered that certain of the patients had very shrewd insight into the unconscious needs of the disturbing element, and showed, in a general way, unusual understanding and tolerance for the personal problems of the disturber. Indeed, one might fairly say that the presence of such an individual on the ward, provided he not remain too long, could actually prove to be a binding rather than a disruptive experience for the other participants.

During this visit, as well as during my visit of September, I was particularly impressed during the staff meeting which always follows the group meeting. The nurses and attendants displayed attitudes of kindness, interest and understanding, not only insofar as the patients were concerned but also in relation to one another and the interpersonal situations which inevitably arise in connection with work with disturbed patients. Their understanding of dynamics, both group and individual, was on an unusually sophisticated level, and their emotional involvement in the welfare of the ward was heartening.

Incidentally, a small incident between a new patient and one of the nurses, which I happened to observe, may be worth noting. The patient was playing a guitar, and one of the nurses appeared in the room, listened to him for a while, then asked him to play something. He played a piece for her and she expressed her appreciation. The patient then said to her, "Gosh, you nurses here are different from other places I've been. Most places the

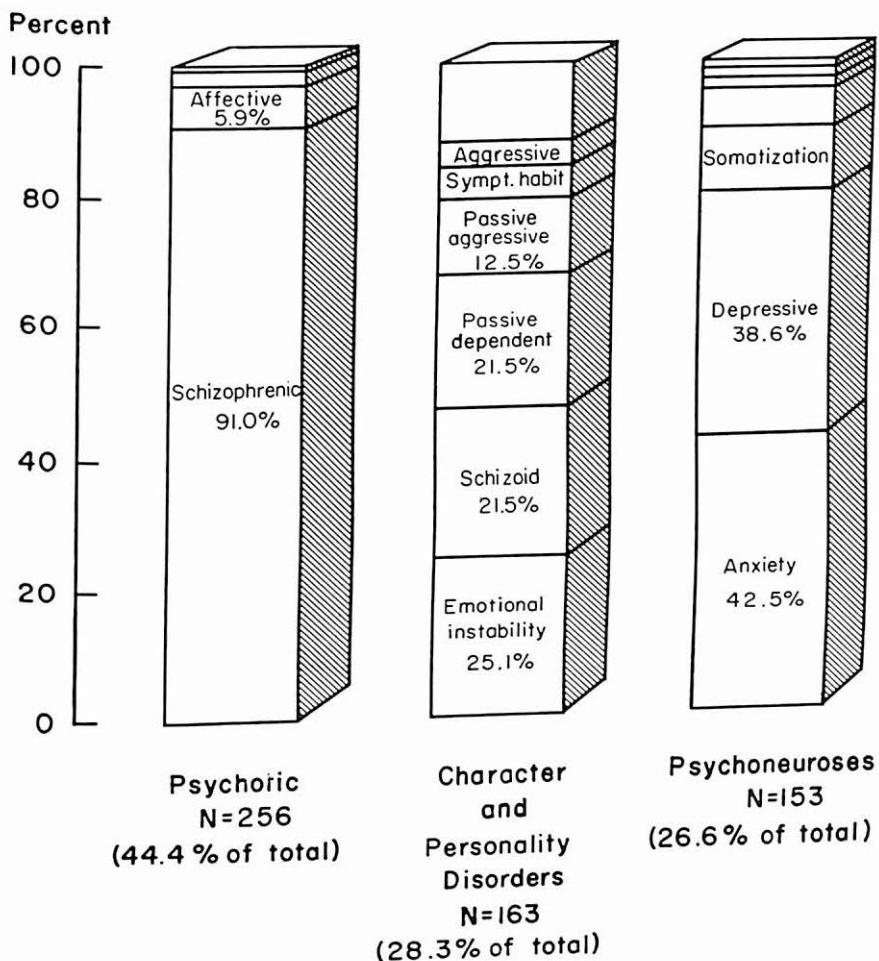
nurses go around with their noses stickin' up in the air, but here you're all nice to us and we feel you're friendly."

During the staff meeting, a subject of particular interest arose: the question of the emotional reactions of the group leader to the hostile patient, and to what degree they can be dissembled, and to what degree and in what manner they should be expressed. The consensus of opinion was that complete objectivity, such as might be maintained during an individual interview with a patient, could hardly be expected in a group, where an emotional response to the 'public insult' is the conventional reaction. Thus, such a sterilized objectivity would not be desirable in a group: on the other hand, it would not be appropriate to give free expression to emotions of resentment or anger. The solution would, therefore, appear to be that such emotional responses should be muted, particularly insofar as counterattack upon a disturber is concerned: nevertheless the group would observe the degree of control exercised, and would share in the interplay as part of their emotional participation in the activity of the group as a whole.

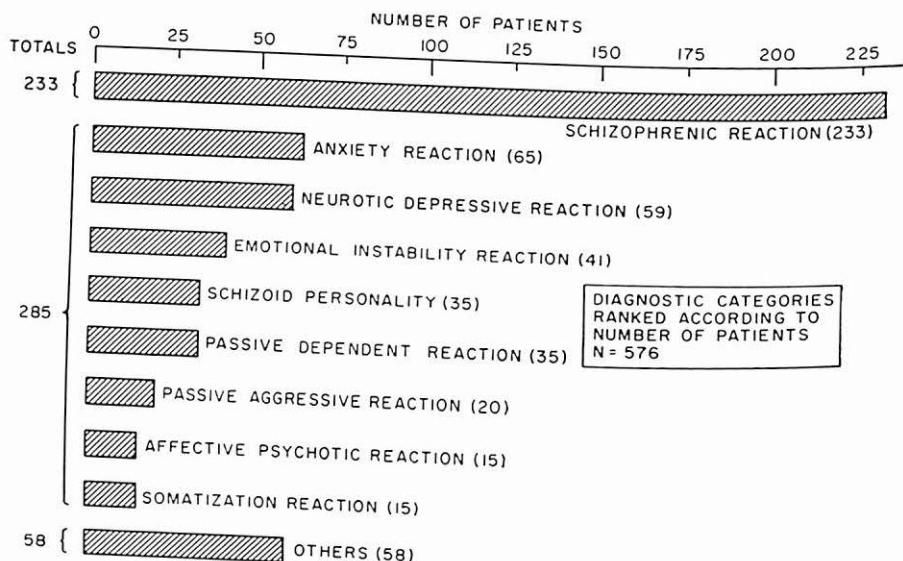
It is my opinion that the therapeutic community mode of treatment, as presently practiced by Captain Wilmer, is one of the most hopeful developments in psychiatry, from both the administrative and psychotherapeutic points of view. It seems highly desirable that the group leader and the medical officer in charge of the ward be one and the same person, and that individual interviews with various of the patients be continued along with the group meetings, so that the leader may have his finger on the pulse, as it were, of the group as a whole.

APPENDIX D

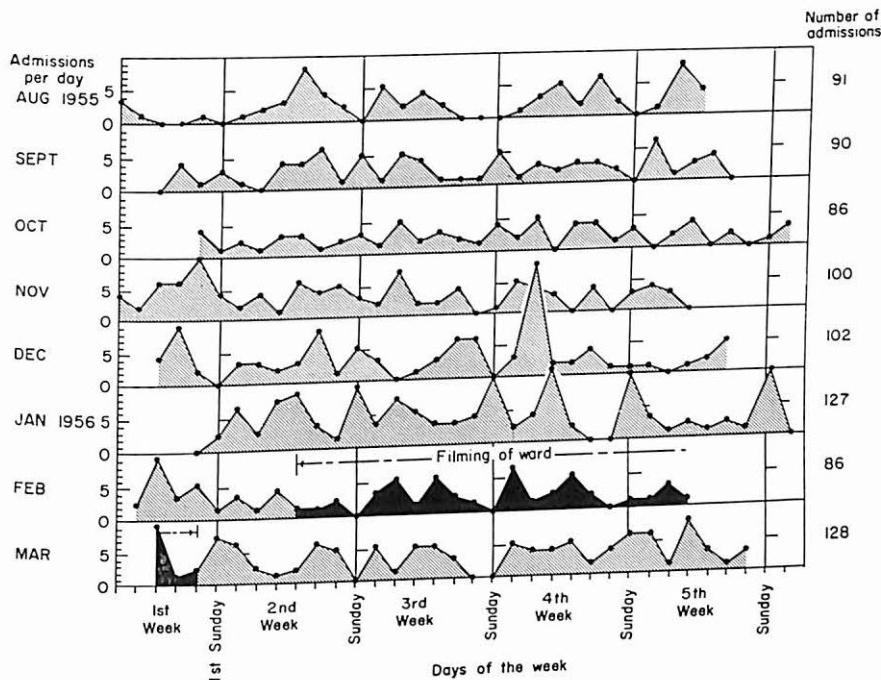
GRAPHS AND DIAGRAMS



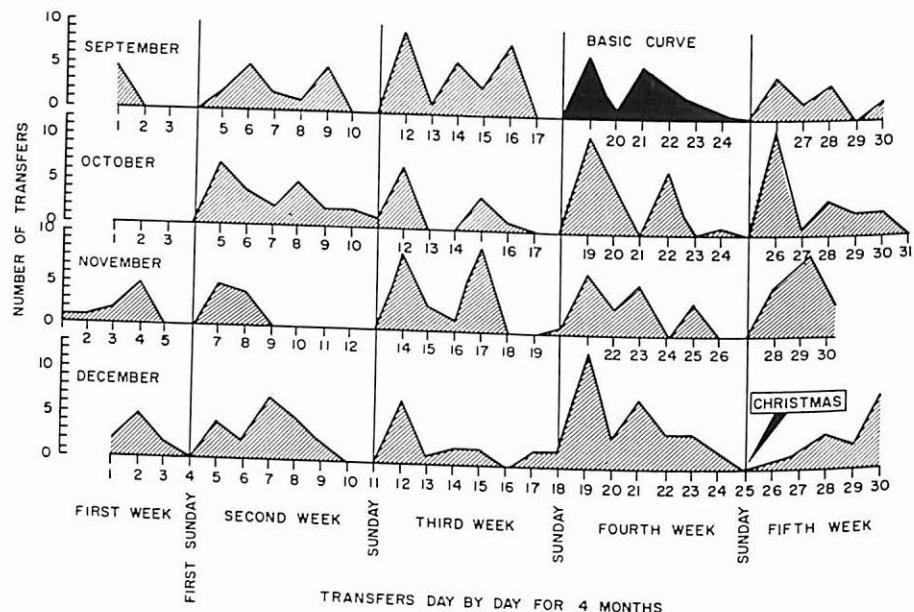
GRAPH 1. Diagnostic Classification of Ward Population (Based on a Representative Sample of 576 Patients).



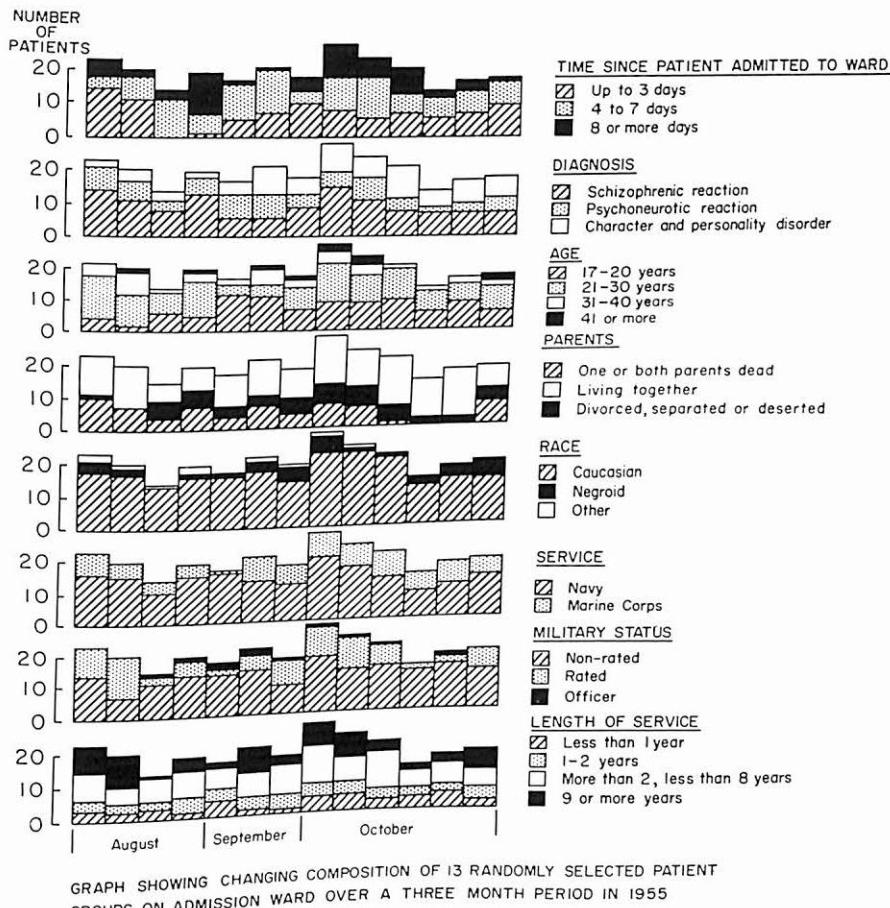
GRAPH 2. Types of Illnesses on the Ward in Order of their Incidence (Based on a Representative Sample of 576 Patients).



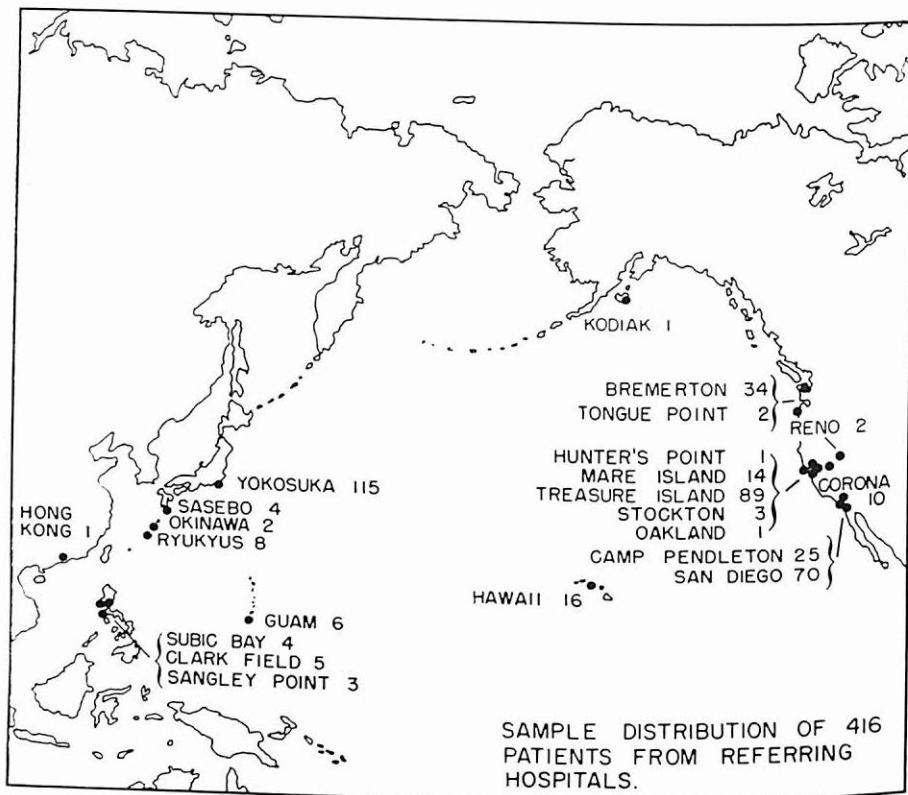
GRAPH 3. Daily Admissions, August 1955 through March 1956.



GRAPH 4. Daily Transfers, September—December 1955.



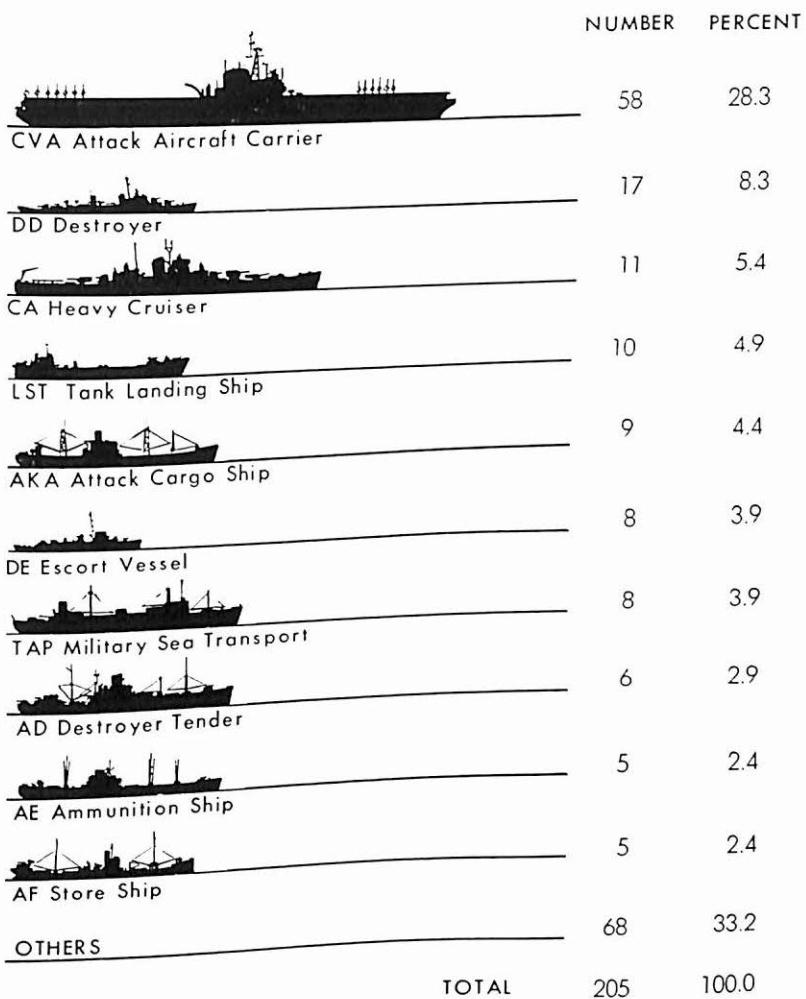
GRAPH 5. Changing Composition of Ward Population in 13 Randomly Selected Weeks, August—October 1955.



GRAPH 6. Sample Distribution of 416 Patients from Referring Hospitals.

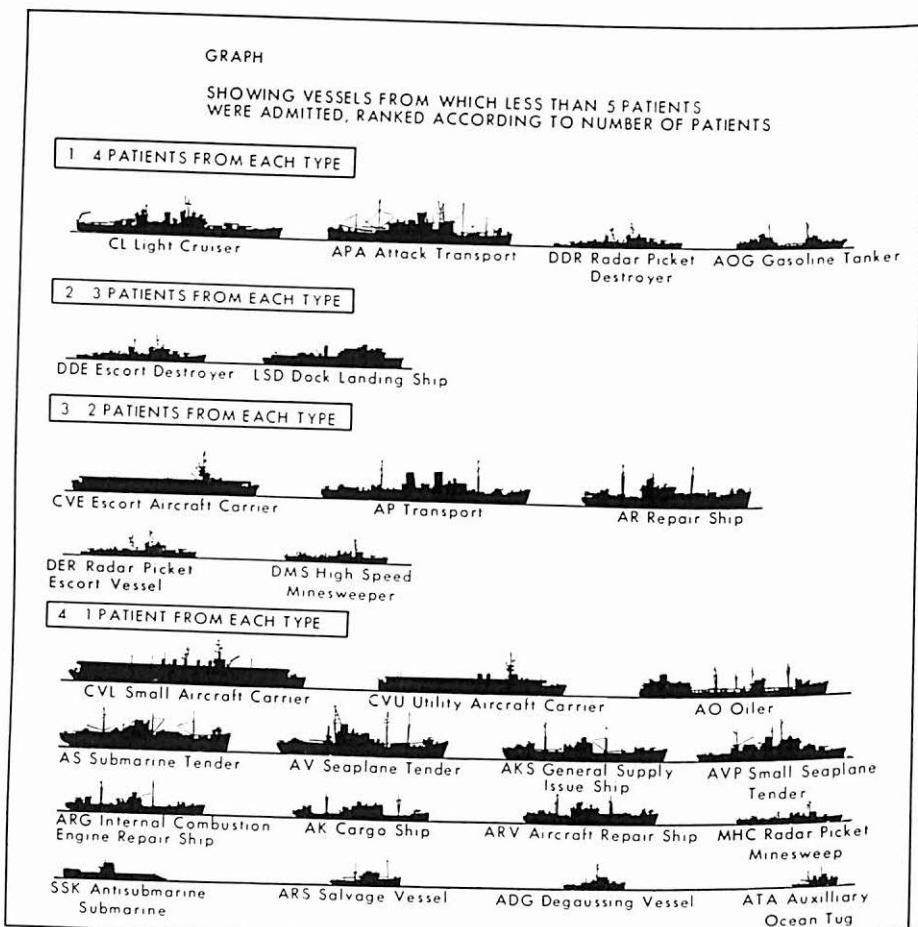
GRAPH

SHOWING TYPES OF VESSELS FROM WHICH
5 OR MORE PATIENTS WERE ADMITTED TO THE
PSYCHIATRIC SERVICE RANKED ACCORDING
TO NUMBER OF PATIENTS

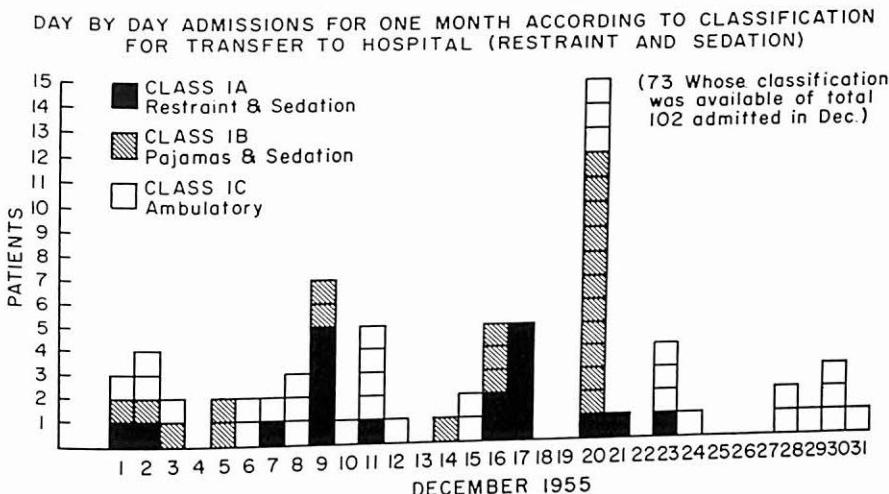


CVA Attack Aircraft Carriers were the only vessels from which more than 5 patients per vessel were admitted.

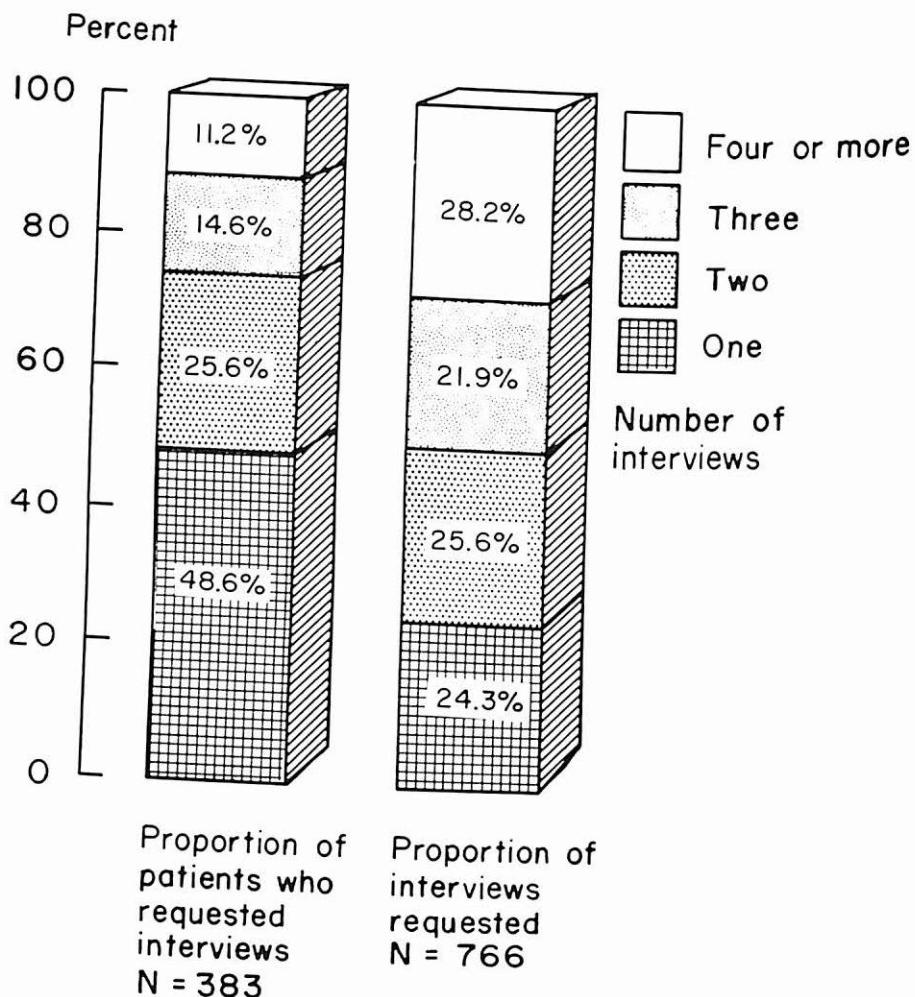
GRAPH 7. Types of Vessels from which 5 or More Patients Were Admitted to the Psychiatric Service.



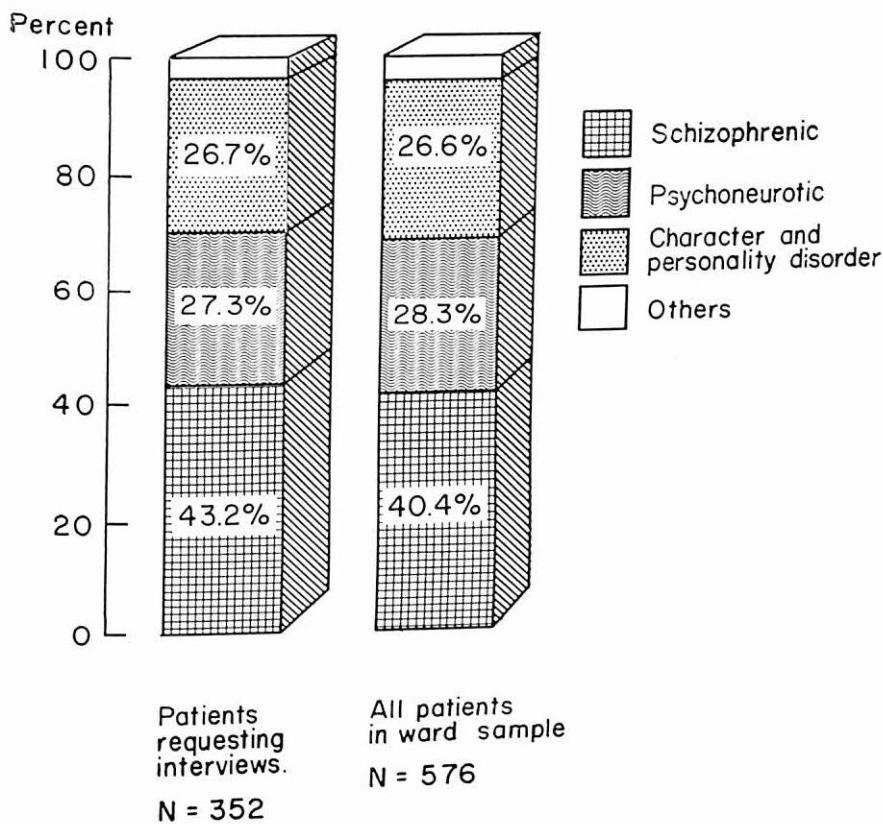
GRAPH 8. Types of Vessels from Which Fewer Than 5 Patients were Admitted.



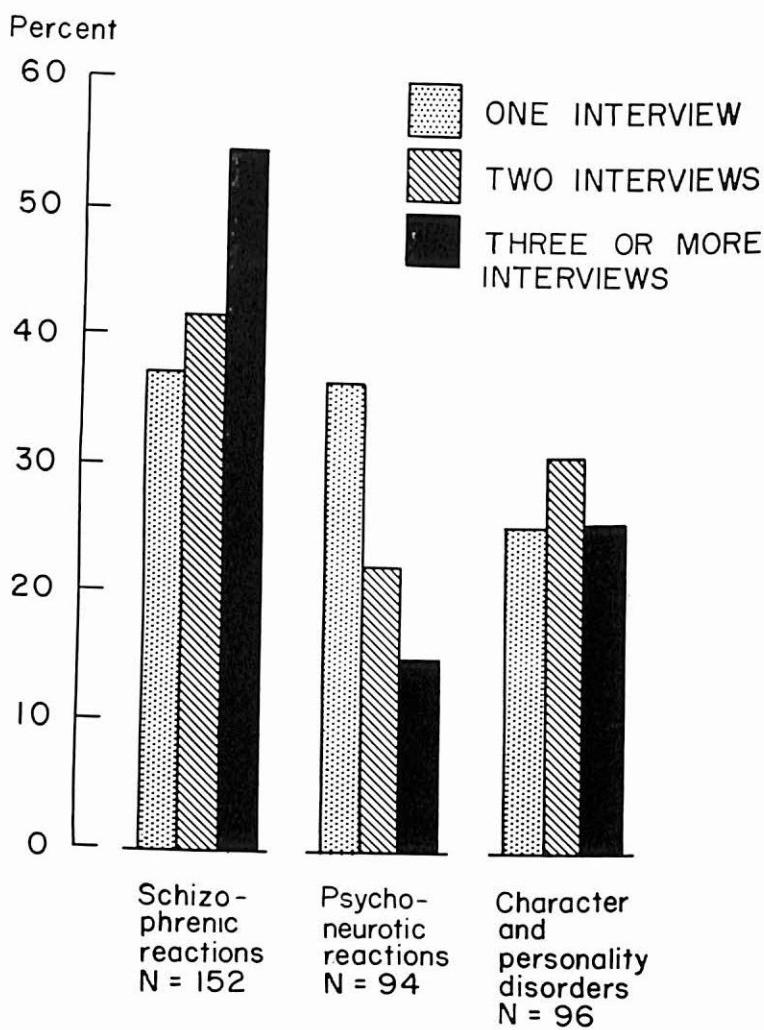
GRAPH 9. Restraint and Sedation: Day-by-Day Admissions for One Month According to Classification for Transfer to Hospital.



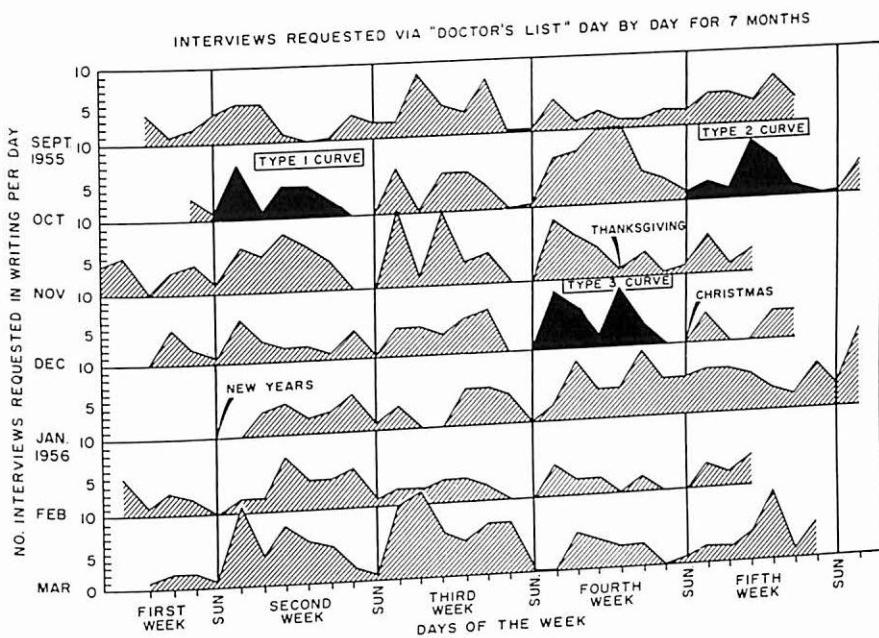
GRAPH 10. Distribution of Single and Multiple Requests for Interviews:
By Proportion of Patients Requesting Interviews and by Proportion of Interviews Requested.



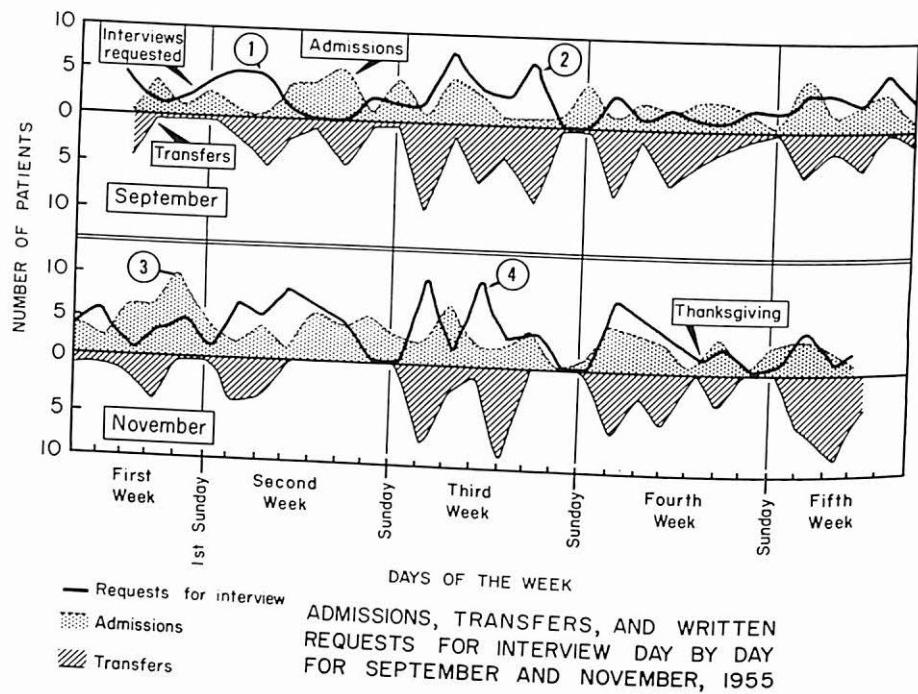
GRAPH 11. Representation of Major Diagnostic Categories: Patients Requesting Interviews Compared with Total Patient Sample.



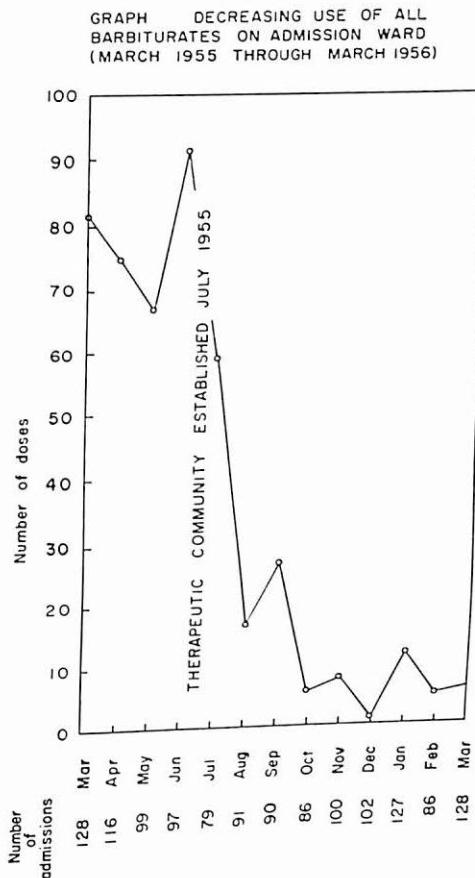
GRAPH 12. Distribution of Single and Multiple Requests for Interviews According to Major Diagnostic Categories.



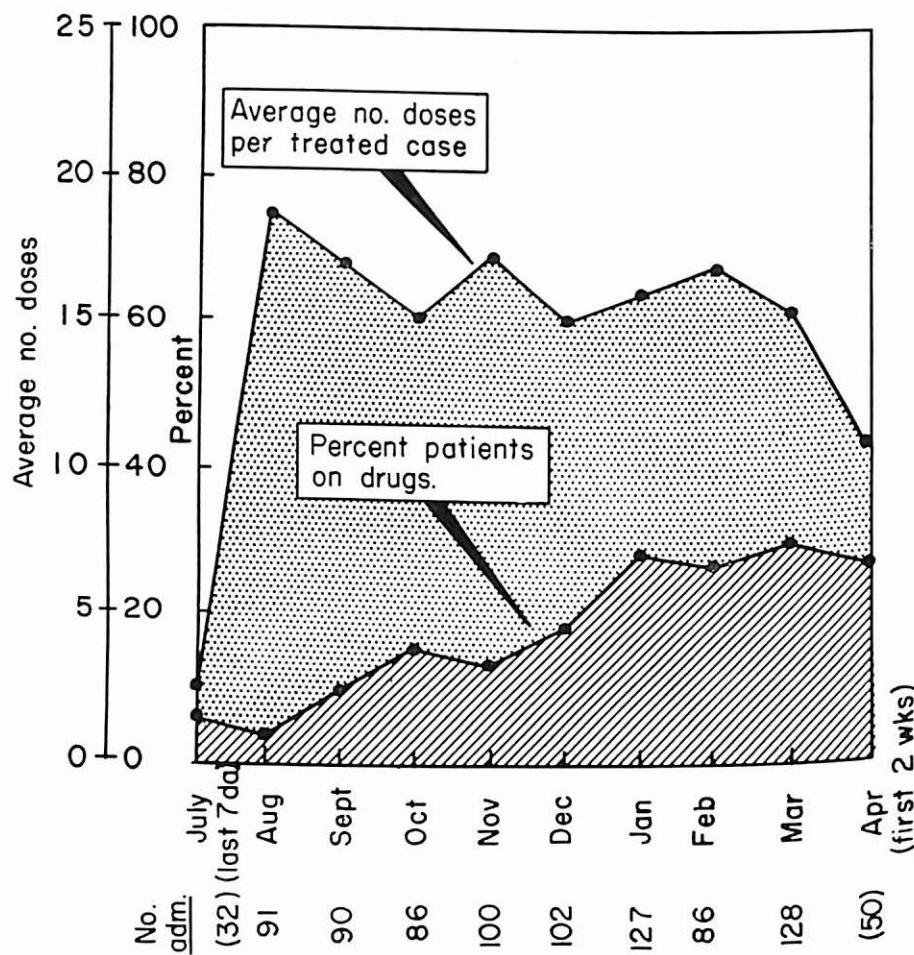
GRAPH 13. Interviews Requested Via "Doctor's List" Day-by-Day for 7 Months.



GRAPH 14. Admissions, Transfers, and Written Requests for Interviews Day-by-Day for September and November 1955.



GRAPH 15. Decreasing Use of All Barbiturates on Admission Ward, March 1955 through March 1956.



GRAPH 16. Percentage of Patients Treated with Ataractic Drugs and Average Number of Doses per Treated Patient by Month, July 1955—April 1956.

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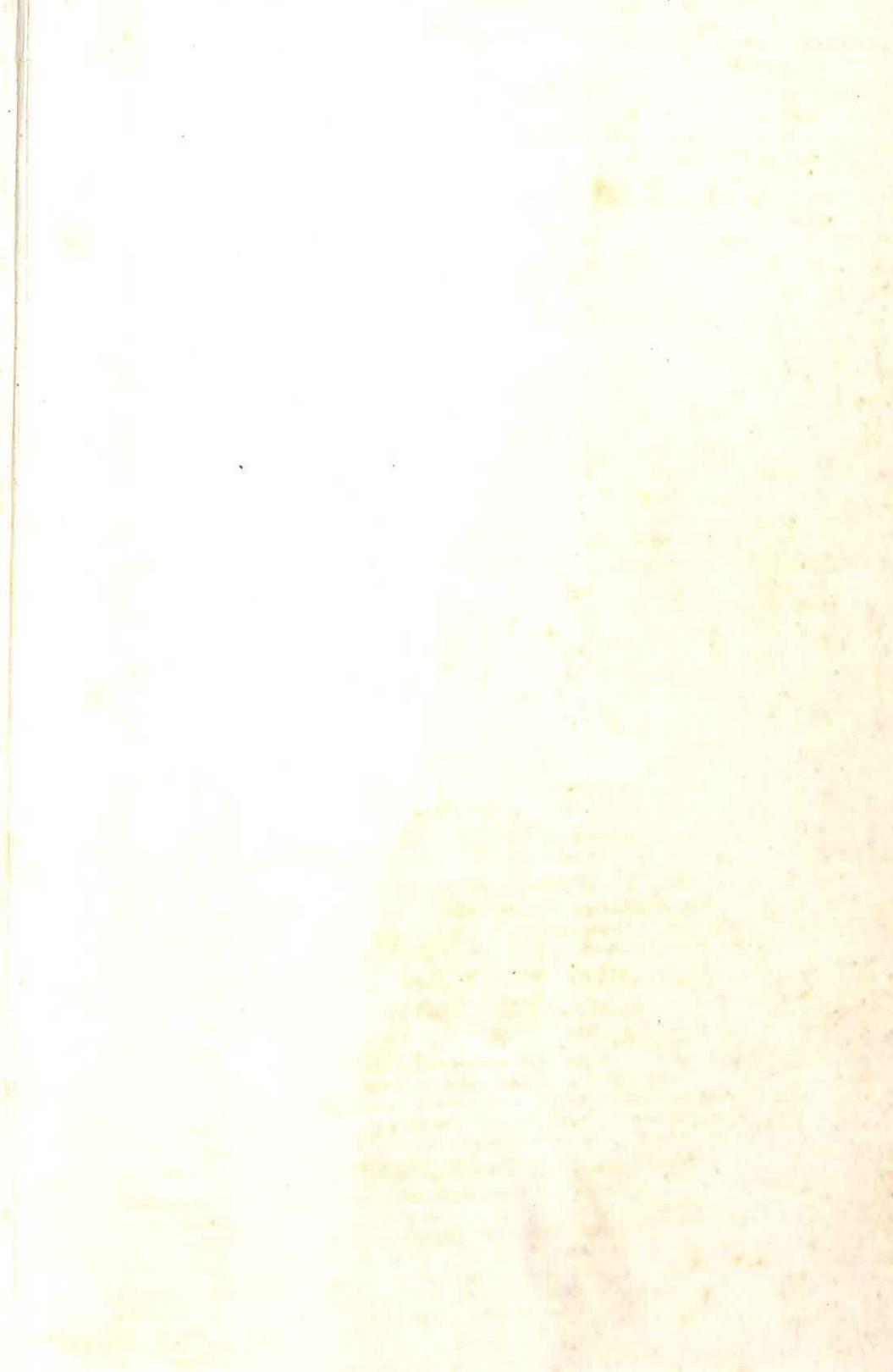
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